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Message from the President

Authored by Dr. Teri A. Murray, PhD, RN
Board President

A Few Years in Review

Murray

As I end my term, I would like to highlight a few key accomplishments of the Board of Nursing during the last few years in the areas of fiscal management, licensure, practice, education, and discipline.

I am most proud of the sound fiscal management of the revenue and expenditure streams. This successful management has resulted in lower licensure fees for the nurses.

The hiring of an in-house attorney and paralegal has realized enormous savings and reduced the time spent on processing discipline cases from 3 to 4 years to 3 to 6 months.

In recognition and gratitude for the service of the senior nurses in Missouri, the Board established the "Golden Certificate." This Certificate commemorates nurses with at least 50 years of service as a nurse in Missouri.

The Impaired Nurse Program was established as an alternative to discipline for nurses with chemical/substance dependency. It is anticipated this program will be fully operational within 1 to 2 years.

An online survey has been developed for nurses to complete when he or she renews the license online. The information gleaned from this survey will provide data on the supply of and demand for nurses in Missouri. This data can be used to inform state and local decision-makers regarding the recruitment, education, and employment of nurses in Missouri.

The Board adopted a delegation decision making tool and scope of practice decision tree to assist nurses in making effective decisions regarding practice, http://pr.mo.gov/boards/nursing/MODecision_Making_Model.pdf). This tool allows the nurse to use judgment, skill, and knowledge to determine if he or she may perform the activity according to prevailing and acceptable standards of nursing care.

In recognition of the need to ensure patient safety, the Board sponsored the Just Culture conference in conjunction with the Missouri Commission on Patient Safety and established an initiative to incorporate just culture into the Board's investigation and discipline procedures.

The Minimum Standards for Professional and Practical Nursing Programs were revised and became effective December 30, 2007. Noteworthy revisions include the change in computation of the licensure pass rate from a fiscal to a calendar year and including graduates only up to one year after graduation in the program's pass rate.

The Board made a significant investment in the professional development of nurse educators in Missouri. The Board co-sponsored the Midwest Leadership Institute for Nurse Educators for the last two years. This year, the Board paid the attendance fee for one representative from each approved nursing program.

The Board also received the authority to seal complaints in cases against a licensee where no disciplinary action was taken by the Board. In the past, this information could be released under certain circumstances even if no disciplinary action was taken by the Board.

These are just a few of the many good works and accomplishments of the Board of Nursing on behalf of the nurses in Missouri. I thank the board members, board staff, and Missouri nurses for allowing me the privilege and honor to serve in the capacity of President.

Executive Director Report

Authored by Lori Scheidt, Executive Director

Controlled Substance Prescriptive Authority for Advanced Practice Registered Nurses

Scheidt

Senate Bill 724 filed by Senator Delbert Scott (Republican—District 28) passed and has been signed by the Governor. Senate Bill 724 grants advanced practice registered nurses the ability to apply for a certificate of controlled substance from the Board of Nursing and allow those who qualify the authority to prescribe controlled substances schedules III through V while operating under a collaborative practice agreement.

Representative Kenny Jones (Republican—District 117) filed House Bill 1620 which is a similar bill.

These are brief highlights of the bill.

- Authorizes an APRN who holds a certificate of controlled substance prescriptive authority from the board of nursing under section 335.019, RSMo, and who is delegated the authority to prescribe controlled substances under a collaborative practice arrangement under section 334.104, RSMo, to administer, dispense or prescribe controlled substances listed in Schedules III, IV or V.
- Prohibits the delegation of administering Schedule III, IV and V controlled substances for the purpose of inducing sedation or general anesthesia for therapeutic, diagnostic, or surgical procedures.

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- Limits Schedule III narcotic prescriptions to 120 hour supply without refill.
- Allows CRNA to continue to provide anesthesia services without a collaborative practice agreement (CPA) if under supervision of certain professionals; permits CRNA to enter into a CPA that does not delegate controlled substance prescriptive authority.
- Limits the physician from entering into a CPA with no more than 3 full-time equivalent APRNs and provides exemption for hospital employees providing inpatient care services in a hospital or population based public health services.
- Requires the physician to determine and document the completion of at least a one month period of time that the APRN must continuously practice with the collaborating physician if in a setting where the physician will not be continuously present.
- Prohibits any new agreement from superseding any current hospital licensing regulations governing medication orders approved by the hospital's medical staff and pharmaceutical therapeutics committee.
- Grants any physician the right to refuse to enter into a CPA without penalty and prohibits any contract or other agreement from limiting the physician's authority over any protocol or standing order or delegation of authority to an APRN as long as there is no violation of applicable standards for safe medical practice established by hospital medical staff.
- Grants the APRN the right to refuse to enter into a CPA without penalty.
- Changes the term to "advanced practice registered nurse" and limits the APRN title to certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist and certified clinical nurse specialist.
- Authorizes the Board of Nursing to grant controlled substance certificates to APRNs meeting specific requirements.
- Requires APRN applying for a controlled substance certificate to submit: proof of completion of a pharmacology course; documentation of 300 hours preceptorial experience in the prescription of drugs, medications and therapeutic devices with a qualified preceptor; evidence of at least 1000 hours of specific APRN practice; and must be in controlled substance CPA with a qualified physician.
- Clarifies what must be included in a written collaborative practice arrangement (CPA).
  1. Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the advanced practice registered nurse;
  2. A list of all other offices or locations besides those listed in subdivision (1) of this subsection where the collaborating physician authorized the advanced practice registered nurse to prescribe;
  3. A requirement that there shall be posted at every office where the advanced practice registered nurse is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by an advanced practice registered nurse and have the right to see the collaborating physician;
  4. All specialty or board certifications of the collaborating physician and all certifications of the advanced practice registered nurse;
  5. The manner of collaboration between the collaborating physician and the advanced practice registered nurse, including how the collaborating physician and the advanced practice registered nurse will:
     (a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;
     (b) Maintain geographic proximity; and
     (c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;
  6. A description of the advanced practice registered nurse's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the nurse to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;
  7. A list of all other written practice agreements of the collaborating physician and the advanced practice registered nurse;
  8. The duration of the written practice agreement between the collaborating physician and the advanced practice registered nurse; and
  9. A description of the time and manner of the collaborating physician's review of the advanced practice registered nurse's prescribing practices. The description shall include provisions that the advanced practice registered nurse shall submit documentation of the advanced practice registered nurse's prescribing practices to the collaborating physician within fourteen days. The documentation shall include, but not be limited to, a random sample review by the collaborating physician of at least twenty percent of the charts and medications prescribed.

The Missouri State Board of Nursing has already engaged the other regulatory agencies such as the Bureau of Narcotics and Dangerous Drugs, Department of Health, Board of Pharmacy and Board of Healing Arts to start working on making changes to the rules. The rulemaking process is time-consuming. The proposed amendments to existing rules are published in the *Missouri Register,* which is generally issued on the 1st and 15th of each month. The public has at least 30 days from the date of the rule's appearance in the Missouri Register to submit written comments to the Board of Nursing. The Board of Nursing may hold public hearings after the 30th day of the comment period as another means of addressing public concerns or comments. Within the next 60 days, all public comments are compiled and carefully reviewed by the Board and rule language modifications may result. The Final Order of Rulemaking is filed with The Joint Committee on Administrative Rules (JCAR), composed of both senators and representatives, who have 30 days to review the proposed new rule or proposed amendment to existing rule, which may or may not result in JCAR calling for a hearing to take place before their Committee. If no JCAR hearing is set within their 30-day review, the Final Order of Rulemaking is filed with the Secretary of State's Office. The Final Order of Rulemaking appears in the *Missouri Register* approximately 30-45 days later. The Final Order of Rulemaking then appears in the *Code of State Regulations* at the end of the month in which the Final Order of Rulemaking was published in the *Missouri Register.* The Final Order of Rulemaking becomes effective 30 days after its appearance in the *Code of State Regulations.*

The Board of Nursing cannot issue a certificate of controlled substance prescriptive authority until the rules are final. Therefore, APRNs cannot begin prescribing controlled substances until the rules are final and the APRN possesses the certificate of controlled substance prescriptive authority.

The Board of Nursing is committed to open, participatory and effective rule making. The Missouri Nurses Association and Missouri Hospital Association, as well as other nursing associations, will be heavily involved in providing advice to the Board on the rules regarding the practical implementation. The regulatory agencies I mentioned earlier will be heavily involved to ensure that the process is not a barrier to practice to those who qualify.

We will post updates of our progress on our website. When the rules and forms are finalized, we will share with all currently recognized APRNs in the State of Missouri by mail.

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Other Bills

Only two bills that I mentioned in the last edition of the newsletter passed. They are Senate Bill 788, referred to as the Department Reorganization Bill. It was filed by Senator Delbert Scott (Republican—District 28). Since an August 28, 2006 Governor's Executive Order, the Division of Professional Registration has been operating under a newly created Department of Insurance, Financial Institutions and Professional Registration. Senate Bill 788 formally revises the statutes to implement the Governor's Executive Order.

The other bill that passed was Senate Bill 1190 filed by Senator Gary Nodler (Republican—District 32). It authorizes the Division of Professional Registration to reduce licensure fees by emergency rule under certain circumstances.

License Renewal Survey

The Board of Nursing is continuing to work with many stakeholders to collect information to describe the supply of and demand for nurses in Missouri. LPNs that renewed online were given the opportunity to complete an online survey. The Board mailed 24,586 LPN renewal notices for the May 2008-2010 renewal period. A total of 6,228 renewed online. Of that number, 1,130 completed the online survey. Data from this survey will be used to inform state and local decision makers regarding the recruitment, education, and employment of nurses in Missouri. A summary of the data collected follows.

3. What was your first nursing degree that led to your first nursing license?

	Response Percent	Response Count
Practical nursing certificate/degree/diploma	97.0%	1101
Associate degree	1.2%	14
Diploma	1.8%	20
Baccalaureate/Bachelors	0.0%	0
Masters	0.0%	0
Doctoral	0.0%	0
answered question		1135
skipped question		14

4. What is the highest degree you have earned?

	Response Percent	Response Count
Practical nursing degree/certificate/diploma	92.8%	1057
Associate degree in nursing	4.9%	56
Diploma in nursing	1.0%	11
Baccalaureate/Bachelors in nursing	0.6%	7
Masters in nursing	0.0%	0
Masters in another field	0.7%	8
Doctorate in nursing	0.0%	0
Doctorate in another field	0.0%	0
answered question		1139
skipped question		10

5. Are you currently pursuing or planning to pursue a higher degree?

	Response Percent	Response Count
Yes	63.9%	732
No	36.1%	413
answered question		1145
skipped question		4

6. What is the major reason you are not or do not plan to pursue a higher degree?

	Response Percent	Response Count
No interest	20.9%	86
Expenses	40.9%	168
Family or personal reasons	37.2%	153
Not available in my area	1.0%	4
answered question		411
skipped question		738

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7. What is your current employment status?

	Response Percent	Response Count
32 or more hours per week in nursing or a related field	80.0%	898
Less than 32 hours per week in nursing or a related field	9.5%	107
Employed, but not in nursing	3.6%	40
Not employed, seeking employment in nursing or related area	2.8%	32
Not employed, seeking employment outside of nursing	0.4%	4
Not employed and not looking for a job	2.8%	32
Retired	0.9%	10
answered question		1123
skipped question		26

8. Identify your primary employment setting in which you work the most hours each month

	Response Percent	Response Count
Hospital	18.9%	207
School of Nursing (RN or LPN)	0.6%	7
Self-employed/Private Practice	0.3%	3
School Health	2.6%	28
Occupational/Industrial Health	0.9%	10
Office/Clinic	17.2%	188
Public/Community Health	1.2%	13
Home Health	8.3%	91
Ambulatory Care/Surgery	1.3%	14
Government Local/State/Federal/Military	4.6%	50
Other	7.2%	79
Traveling/Temporary Nurse	1.1%	12
Hospice	2.3%	25
Insurance company/health plan	1.0%	11
Long-Term Care	**29.0%**	318
Business/Industry/Association	0.5%	6
Prison	3.1%	34
answered question		1096
skipped question		53

9. Identify your primary type of position.

	Response Percent	Response Count
Scheduling/Admissions	0.9%	10
Office/Clinic Nurse	18.7%	197
School Nurse	2.7%	29
Charge Nurse/Team Leader	23.1%	244
Administrator or Assist. Adm.	1.6%	17
Supervisor/Management	9.3%	98
Staff Nurse	**38.8%**	409
Consultant/Private Practice	0.2%	2
Nurse Midwife	0.0%	0
Nurse Practitioner	0.3%	3
Certified Registered Nurse Anesthetist	0.0%	0
Clinical Nurse Specialist	1.3%	14
Researcher	0.4%	4
Informatics	1.3%	14
Educator, Academics	0.4%	4
Educator, Service Setting	0.9%	10
answered question		1055
skipped question		94

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10. Select your primary practice area.

	Response Percent	Response Count
Allergy/Immunology	0.4%	3
Burns	0.0%	0
Cardiac	3.0%	24
Critical Care	1.1%	9
Emergency/Urgent Care	4.3%	35
General/Family Practice	15.1%	122
Geriatrics/Elder Care	**34.0%**	274
Medical-Surgical	15.6%	126
Obstetrics/Gynecology	2.9%	23
Oncology	1.5%	12
Ophthalmology	0.1%	1
Orthopedics	1.7%	14
Pediatrics	9.1%	73
Psychiatric/Mental Health	7.2%	58
Surgery	4.0%	32
answered question		**806**
skipped question		**343**

11. To assist in projecting the supply of nurses in the future, please tell us how much longer you plan to practice nursing.

	Response Percent	Response Count
1-5 years	5.5%	55
6-10 years	12.3%	124
11-15 years	14.1%	142
16-20 years	15.9%	160
21-25 years	13.3%	134
26-30 years	13.4%	135
More than 30 years	18.0%	181
Don't know	7.5%	76
answered question		**1007**
skipped question		**142**

12. How many hours of nursing continuing education (CEs) did you obtain in the last 2 years?

	Response Percent	Response Count
6-10 hours	**31.5%**	311
11-15 hours	13.9%	137
15-30 hours	13.9%	137
Over 30 hours	13.9%	137
None	26.9%	266
answered question		**988**
skipped question		**161**

13. Have you changed employers in the last 2 years?

	Response Percent	Response Count
Yes	38.8%	391
No	**61.2%**	617
answered question		**1008**
skipped question		**141**

14. Major reason for change in employment?

	Response Percent	Response Count
Dissatisfaction with assignment	13.1%	51
Dissatisfaction with salary	**14.4%**	56
Returning to school	6.4%	25
Family or personal leave	2.1%	8
Retirement	1.0%	4
Physical demands of job	3.4%	13
Employer/employee conflict	13.4%	52
Career promotion	13.7%	53
Age	0.8%	3
Childbearing/Childrearing	3.9%	15
Health	2.3%	9
Travel	3.4%	13
Relocation	12.6%	49
Nurse to Patient Ratio	9.5%	37
answered question		**388**
skipped question		**761**

15. Rate your level of satisfaction with the following.

Factor	Very satisfied	Satisfied	Neither satisfied or dissatisfied	Dissatisfied
Salary/Wages	7.6% (83)	**36.9% (402)**	22.3% (243)	27.7% (302)
Benefits	11.8% (128)	**35.3% (384)**	21.2% (230)	21.8% (237)
Skill of nurses you work with	16.8% (181)	**48.4% (523)**	23.9% (258)	9.4% (102)
Adequate staff	9.0% (97)	27.5% (298)	20.5% (222)	**31.0% (335)**
Quality nursing leadership	13.9% (150)	**40.7% (439)**	24.4% (263)	16.8% (181)
Strong nursing representation in the organizational structure	12.3% (133)	**37.9% (409)**	28.8% (311)	16.8% (181)
Safe physical work environment that supports nursing	21.7% (234)	**48.0% (518)**	16.7% (180)	10.7% (115)
Work/life balance	14.9% (161)	**46.2% (499)**	21.4% (231)	14.9% (161)
Quality of care provided	29.2% (315)	**48.9% (528)**	12.3% (133)	8.3% (90)
Adequate resources and support	16.4% (177)	**42.5% (458)**	22.4% (241)	15.8% (170)
Educational and professional growth opportunities	15.2% (164)	**31.8% (343)**	28.6% (309)	19.3% (208)
Image of nursing	19.7% (213)	**47.3% (511)**	19.2% (207)	11.2% (121)
Interdisciplinary relationships	12.3% (132)	**45.6% (490)**	29.1% (312)	10.1% (109)

The Legal Perspective

Authored by Mikeal R. Louraine, B.S., J.D.
Legal Counsel

Update on Baze and Bowling v. Kentucky et. al.

Louraine

On April 16, 2008, the United States Supreme Court handed down its decision in this case. The Court found that the three-drug method of execution that the State of Kentucky used did not violate the constitutional ban against cruel and unusual punishment. They found that the possibility of pain to the condemned prisoner did not rise to the level of a constitutional violation. Further, the fact that arguably better methods to execute prisoners exist does not make this particular method unconstitutional.

The Supreme Court later decided not to hear the Taylor v. Missouri case which involved similar issues. While Mr. Taylor's attorneys were quoted as saying that their client's case involved different issues, the Court disagreed and refused to hear the case. That refusal means that the decision issued by the 8th Circuit Federal Court of Appeals will stand and the State of Missouri may resume use of the three-drug execution method. Attorney General Jay Nixon has requested the Supreme Court of Missouri to resume setting execution dates for inmates on death row. Under Missouri law, the Supreme Court sets execution dates upon the request of the Attorney General. Though they were under no legal obligation to do so, the Missouri Supreme Court had stopped setting execution dates while the Taylor case was pending. The Court has resumed setting dates and has set September 17th as the execution date for John Middleton, sentenced to death for a 1995 double killing.

In the past I've written that nurses who choose to assist in the execution process are protected from being identified in the press or otherwise and the legislature has prohibited the Board from seeking discipline against a licensee for participating in the process. If you wish to volunteer to serve on the state's death penalty team, you should contact the Department of Corrections.

Board Meeting Questions

At the most recent full Board meeting, during the question-and-answer session, the Board received a couple of excellent questions. While we've heard numerous variations of this first topic, this student got right to the heart of the issue. "Does the Board take into account the licensee's manner when they appear before the Board?" While the correct answer is that every case is adjudged on its own merits, human nature will tell you that how the licensee reacts and responds to the Board will be taken into account. I've written in the past that licensees who appear before the Board should dress professionally and treat the Board with respect. That remains sound advise.

The second question involved a case where the licensee decided not to accept the Board's recommendation for discipline. While the licensee stipulated that their license was subject to discipline for violating the Nursing Practice Act, they felt that the level of discipline recommended by the Board was too harsh. The licensee requested a hearing before the Board to determine the appropriate level of discipline. The question arose then, is the Board limited by its earlier recommendation? In other words, if the Board recommended one year of probation, is it prohibited from going over that level, i.e. two years of probation. Conversely, is the Board prohibited from recommending less than the original recommendation? The answer is no, the Board's options are not limited or 'capped' by its earlier recommendation. While the Board absolutely cannot punish a licensee for exercising their right to a hearing, the Board can take into consideration any new information they receive at the hearing. As referenced in the first question, the licensee's demeanor can be a factor. In cases involving chemical dependency issues, the licensee may bring evidence of treatment and recovery that the Board did not have when they made the initial recommendation. In cases involving practice issues, the licensee may have obtained continuing education hours since the time of the recommendation. In short, once the licensee makes the decision to not accept the Board's original recommendation, that recommendation is negated and has no bearing on the Board's final decision.

As always, thanks to the students who come to the hearings and pay enough attention to come up with good questions.

Education Report

Authored by Bibi Schultz, RN
MSN, Education Administrator

Missouri State Board of Nursing Education Committee Members:

- Teri Murray, PhD, RN, Chair
- K'Alice Breinig, RN MN
- Kay Thurston, ADN RN

Schultz

Program Surveys

I am excited to report that throughout the last few months we have been busy visiting nursing programs throughout the state. I would like to take this opportunity to especially thank all of you who have been involved with nursing program surveys so far. It is a pleasure as well as a privilege to have the opportunity to work with nurse educators in this region. As you know, in compliance with U.S. Department of Education guidelines, a second surveyor has accompanied me to all full-program survey visits. Your warm welcomes, awesome accommodations and efficient working relationships with surveyors are greatly appreciated.

As of June 1st, 2008 we have completed twenty-one nursing program surveys along with routine duties. At this point, all 2008 program surveys have been scheduled and we will begin scheduling 2009 visits very soon. As you may remember, the State of Missouri currently has 105 approved nursing programs. By the end of this year, we plan to have visited 37 of such programs.

Currently Board members, education consultants, and board staff are serving as the second surveyor. We are very interested in acquiring additional qualified nursing professionals to assist in this process. A special invitation will go out to nursing professionals currently involved in Missouri nursing programs to assist me in conducting program visits. We would also like to invite nursing professionals currently practicing nursing in Missouri hospitals, serving as nursing education consultants or serving Missouri citizens in other capacities to assist with survey processes. We are prepared to supply nursing professionals interested in serving as an adjunct surveyor with qualification and confidentiality requirements related to the survey process. Contact us at the Board office for more information.

The on-site portion of each program survey is usually completed within an 8-hour work day. The survey process is facilitated through careful review of program materials prior to the actual visit. Program survey preparation and report completion is the responsibility of the Board's Education Section. Once we receive the nursing program's self-study report (e-mailed to program administrators at the time of visit scheduling), the report, as well as, all submitted program materials is reviewed by Board staff and the preliminary report is compiled. The preliminary report becomes the base for conducting the program survey. Upon completion of the program on-site survey, the actual survey report is compiled. The report is then reviewed by the adjunct surveyor and once it is reviewed and approved, the survey report is submitted to the nursing program administrator for review and correction of any factual errors. Once received back at our office, the survey report is corrected, if necessary. Each survey report is then submitted to the Board's Education Committee members for review and approval. The report and the committee's recommendation are then submitted to the Full Board during the next quarterly meeting for a final approval decision. The nursing program is notified shortly thereafter.

Again, I would like to thank all of you for your interest and cooperation in this process and invite nursing professionals throughout the state to allow me to involve you in this important regulatory process.

Discipline Corner

Authored by Janet Wolken, MBA, RN
Discipline Administrator

Missouri State Board of Nursing Discipline Committee Members:

- Charlotte York, LPN, Chair
- K'Alice Breinig, RN, MN
- Autumn Hooper, RN
- Amanda Skaggs, RNC, WHNP

Wolken

In the current employment arena more and more companies are requiring pre-employment drug screens and routine drug screens either for cause or randomly.

Whenever a non prescribed medication is discovered in your system the Board of Nursing may receive a complaint on your license. The violation of the Practice Act falls under 335.066.2.(1) Use or unlawful possession of any controlled substance as defined in chapter 195, RSMo, or alcoholic beverage to an extent that such impairs a person's ability to perform the work of any profession licensed or regulated by sections 335.011 to 335.096 or 335.066.2.(14) Violation of the drug laws or rules and regulations of this state, any other state or the federal government.

A person should never borrow nor lend someone a prescription medication, no matter what the medication. If you have a headache or cannot sleep, take an over the counter medication. Do not take a family member's or friend's prescription medication. In addition to the medical problems a non prescribed medication may cause, it may also cause licensure problems. If you do not have a valid prescription for a medication and you test positive, there is cause to discipline your license.

Another problem that arises is when a person keeps old prescriptions. When a person receives a prescription for an acute condition such as dental work, when the pain related to this condition is no longer a problem the medication prescribed for this condition should be destroyed. Do not store it in your medicine cabinet for a year and then take it for a pain unrelated to the initial condition. If you have a positive drug screen the prescription may no longer be considered valid and it will be considered a positive screen possibly resulting in termination.

If you have prescription medications, do not share them with family or friends. It is not with in the scope of practice of a Registered Professional Nurse or a Licensed Practical Nurse to diagnose or prescribe.

The policies and procedures of different facilities and companies vary when it comes to the frequency of drug testing. Most facilities have a zero tolerance policy when it comes to the use of drugs and alcohol. Do not have a drink at lunch and plan on working the evening shift. Do not mow the lawn in the late afternoon and have a drink and plan on working the 7 PM shift. Do not come home at 2 AM after closing down the bars and plan on working the day shift. The majority of people do not know the amount of time it takes for alcohol to clear their system. People are also unaware when they have the odor of alcohol or are slightly impaired. Any level of alcohol in a random or for cause drug screen may result in termination and a complaint on your license.

A positive drug screen for marijuana or cocaine will always result in discipline to your license. If you tend to use these drugs even on a sporadic basis, I would ask that you think long and hard about the repercussions it may have on your license and your livelihood. These are illegal drugs. There is no such thing as a recreational or legitimate use of these drugs.

A question that arises every so often is, "If I have a legitimate prescription and need for a controlled substance may I work?" I do not have a yes or no answer to that question. Instead I answer it with a question of my own. When you take the medication do you or others feel that you are impaired or in any way is your level of consciousness altered? The reason I ask if others notice a change is because often we think our thought process is not altered, but others may notice a change. Is there a change in you memory, your attention span, your fine motor skills? The last thing you would want to happen is to harm a patient due to taking a prescribed medication. If you are able to work without the medication do so, if you are unable to work without it then do not go to work impaired.

When an employer requests that a nurse do a drug screen and the nurse refuses the screen, that is often cause for termination. This is also something that is reported as a complaint against a nurse's license. If you are upset or feel insulted that your employer has requested a drug screen due to documentation issues or other performance issues be sure to look at the long term implications of refusing a drug screen. Take the drug screen; it is to your benefit to prove you're innocent of impairment due to drugs.

When taking any medication prescribed or over the counter be aware of the side effects you may encounter and be sure to always put patient safety first.

Practice Corner

Authored by Debra Funk, RN
Practice Administrator

Missouri State Board of Nursing Practice Committee Members:

- Amanda Skaggs, RNC, WHNP, Chair
- K'Alice Breinig, RN, MN
- Teri Murray, PhD, RN
- Autumn Hooper, RN

Funk

We receive many questions about whether Missouri requires continuing education units (CEUs) for renewal of nursing licenses. As many of you are aware, as you travel across the country as a practicing nurse, each state's Nurse Practice Act varies. Currently in Missouri we do not require CEUs. There has been much research done on this topic and to date, there is no documentation to support the premise that a nurse who completes CEUs for renewal of licensure is a safer practicing nurse.

How to prove continued competence at the regulatory level is difficult and is a subject of much research and discussion by every Board of Nursing around the world. Recently, at the Midyear Conference sponsored by the National Council of the State Boards of Nursing, the audience heard from leaders in nursing from several other countries. They are experiencing the same issues and problems as we are. As Boards of Nursing, we are given the duty to protect the public; provide the public with safe practitioners. In recent studies it was found that the public assumes that the regulatory bodies are continually able to determine that the practitioners that are licensed are competent and safe. In reality, employers tend to be the source for measuring the continued competence of a nurse. The evaluation processes used by employers vary greatly and in some cases are suboptimal.

As nurses we must remember the great responsibility that is placed in our hands every time we go to work. It is our duty to make every effort possible to keep up with the dynamic field of health care so that we may continue to provide safe and efficient care to our patients.

APRN FYI

It was brought to my attention recently that the new law for tamper-resistant prescription pads for all paper Medicaid prescriptions went into effect Apri1 1, 2008. Below is information from the Department of Social Services' website regarding the prescription pad requirements.

Tamper-Resistant Prescription Pads—*Updated*

President George W. Bush signed the "Extenders Law" Saturday, September 29, 2007. This will delay the implementation date for the requirement of all paper Medicaid prescriptions to be written on tamper-resistant paper. Under this new law, all written MO HealthNet prescriptions must be on tamper-resistant prescription pads **effective April 1, 2008**. No other provisions of the original bill regarding tamper-resistant paper were impacted. This is a federal requirement, if any other advisories are forthcoming from the Centers for Medicare and Medicaid (CMS) Missouri HealthNet will publish those as well.

The original federal legislation is intended to reduce Medicaid prescription fraud and requires physicians to begin using tamper-resistant prescription pads for MO HealthNet patients. The law was part of the U.S. Troop Readiness Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 and is aimed at saving state Medicaid programs money by preventing patients from obtaining drugs illegally. The law will deny federal reimbursement to states for Medicaid patients' prescriptions that are not written on tamper-resistant prescription pads.

The purpose of this notice is to clarify the MO HealthNet Division's (MHD), formerly Division of Medical Services, interpretation and implementation of the federal requirements for MO HealthNet medical assistance payment "…amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2)) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." This provision would have become effective on October 1, 2007 now becomes effective April 1, 2008.

To be compliant with the rule, a prescription pad must contain at least one of the characteristics listed below:

One or more industry-recognized features designed to:	**Examples include (but are not limited to):**
• Prevent unauthorized copying of a completed or blank prescription form	• High security watermark on reverse side of blank • Thermochromic ink
• Prevent erasure or modification of information written on the prescription by the prescriber	• Tamper-resistant background ink that shows erasures or attempts to change written information
• Prevent the use of counterfeit prescription forms	• Sequentially numbered blanks • Duplicate or triplicate blanks

Effective for dates of service on and after **October 1, 2008**, a prescription pad must contain all three of the listed characteristics.

This requirement applies to all non-electronic prescriptions, legend and over-the-counter, written for fee-for-service MO HealthNet participants, when MO HealthNet is the primary or secondary payer. Drug Enforcement Administration and Missouri Board of Pharmacy laws and regulations pertaining to all written and electronic prescriptions still apply.

Exceptions to Tamper-Resistant Rx Pads Requirement

Exempt from the tamper-resistant requirement are MO HealthNet:

- Prescriptions, items, or services furnished and amounts expended by or through a MO HealthNet managed care entity (MC+)
- Prescriptions provided in specified institutional and clinical settings for which the drug is not separately reimbursed, but is reimbursed as part of a total service
  - o Institutional and clinical settings defined as: nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), inpatient and outpatient hospital, hospice, dental, laboratory, x-ray and renal dialysis services
- Prescriptions e-prescribed, faxed to the pharmacy from the provider's office, or telephoned to the pharmacy by the provider
- Refills for which the original prescription was filled before April 1, 2008

Emergency Fills

Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

Computer Generated Prescriptions

CMS is offering additional clarification on computer generated prescriptions, including those generated from an Electronic Medical Record (EMR). It has been determined that computer generated prescriptions may meet CMS guidance for the first phase of implementation between April 1, 2008 and October 1, 2008, by containing one or more industry-recognized features designed to prevent erasure or modification of information contained on the prescription. CMS does not believe computer generated prescriptions printed on plain paper will meet all three outlined industry-recognized characteristics.

Therefore, beginning October 1, 2008, computer generated prescriptions must be printed on paper that meets the requirement.

CMS recently issued further guidance on this policy. Specifically, on whether a provider can add a feature, such as gel or indelible ink, calligraphy, or embossed logos to a prescription to make it compliant with the requirements. After policy review CMS has determined that features added to the prescription after they are printed do not meet the requirement of the statute. Features that would make the prescription tamper-resistant include certain types of paper as well as certain items that can be pre-printed on the paper. These features include, but are not limited to: watermarks, micro-printing, and paper on which the word "void" appears when copied.

Additional Resources

1. U.S. Troop Readiness, Veterans' Care, Katrina Recover, and Iraq Accountability Appropriations Act of 2007 (H.R. 2206), section 7002(b).
2. Centers for Medicare & Medicaid Services (CMS) Letter to State Medicaid Director (SMDL #07-012, 08/17/2007).
3. Centers for Medicare & Medicaid Services (CMS) Tamper-Resistant Prescriptions Policy Update, February 2008. www.cms.hhs.gov/DeficitReductionAct/30_Govt Info.asp.

Investigations Corner

Update Your Information

Authored by Quinn Lewis
Investigations Administrator

Lewis

On numerous occasions while conducting an investigation, the Board's investigators have encountered problems when attempting to contact nurses that have had a complaint filed against them. This often occurs when the Board does not have a current address or phone number for the individual.

4 CSR 2200-4.020 paragraph 14 (B)(2) states that if a change of address has occurred since the issuance of the current license the licensee must notify the Board of the address change.

When a nurse is the subject of a Board investigation he/she is notified by mail. At this time, the nurse will be provided with a copy of the complaint and be asked to provide a written response to the allegations within 30 days after receipt of the Board's letter.

If the nurse has moved since he/she last renewed their license and the nurse did not update his/her address with the Board, we have no way of notifying them of the current situation with their license.

In all Board investigations, the nurse is given the opportunity to defend themselves. When a Board investigator cannot find a licensee the complaint does not go away. As mentioned in previous articles, nursing cases are unique in the sense that the person or persons suspected of the conduct is given to us. The Board's investigator is then responsible for collecting evidence in the form of documentation and witness statements. The evidence in most cases will tell the Board if the allegations have merit. Without any response from the licensee in the investigative report, the Board has no choice but to make a one-sided decision.

Nurses have called the Board office upset, because they've heard that the Board has interviewed a former co-worker concerning a complaint which he/she knew nothing about. This often happens after the nurse has moved and has failed to notify the Board of the address change. In response, the individual is informed of the rule mentioned above and a current address and phone number is then obtained. During most of these conversations the nurse will ask, "What would have happened if I would not have called you about the complaint?" When advised that the investigation would continue without his/her side of the story, the most frequent follow up question by the nurse would be, "How can you proceed with an investigation without me knowing there is a complaint against my license?" In response the nurse is reminded that it is his/her responsibility to keep the Board informed of their current address and phone number. While the Board prefers to have the nurse's side of the story, it is not a requirement to complete the investigation. It also should be noted that the Board conducts regulatory investigations not criminal investigations. The investigations do not result in an arrest of the nurse. Any findings may result only in an administrative action.

It is important to emphasize that it is your license at stake. Please take the necessary steps to insure that the Board has your current address and phone number. In addition to being required by 4 CSR 2200-4.020 paragraph 14 (B)(2), keeping your information updated with the Board benefits you by allowing us to keep you informed about important nursing topics, licensure renewal and any concerns regarding your license.

Licensure Corner

Authored by Angie Morice
Licensing Supervisor

Morice

Missouri State Board of Nursing Licensure Committee Members:

- Kay Thurston, ADN, RN, Chair
- Charlotte York, LPN
- Autumn Hooper, RN

LPN renewal deadline was May 31, 2008

The deadline for renewal of Licensed Practical Nurse licenses was May 31, 2008. If you failed to renew during the renewal period, your license is now considered lapsed and you must cease practicing immediately.

To reinstate your license you will need to submit a completed LPN Petition for License Renewal (found on our website at http://pr.mo.gov/nursing.asp) and submit it to our office with the current renewal fee of $37.00 plus a $50.00 penalty fee for a total of $87.00. If you have been working in Missouri on a lapsed license, you will need to include the following:

- A notarized statement from you stating how you discovered that your license had lapsed, date you discovered your license was lapsed, date you notified your employer that you could not practice nursing, date you ceased nursing practice and confirmation that you will not resume employment in a nursing position until your license is renewed.
- A statement from your employer stating the date employer received notification that your license was lapsed, date your employer removed you from a nursing position and confirmation that you will not be allowed to resume a nursing position until your license is renewed.

324.010 Delinquent taxes, conditions for renewal of certain professional licenses

Many Licensed Practical Nurses who recently renewed their license will have received a letter from Department of Revenue regarding delinquent taxes. If you received such a letter, it is important to contact the Department of Revenue immediately at 573-751-7200. Failure to pay your taxes or file tax returns may result in suspension of your nursing license. The suspension is not initiated by the Missouri State Board of Nursing. Therefore, we do not have any information that can be given to you except the above stated phone number.

When your tax compliance letter is received from the Missouri Department of Revenue, make sure that you either mail or fax a copy of the compliance letter to the Board.

Name and address changes

Please notify our office of any name and/or address changes immediately in writing. The request must include your name, license number, your name and/or address change and your signature. Methods of submitting name and/or address changes are as follows:

- By faxing your request to 573-751-6745 or 573-751-0075.
- By mailing your request to Missouri State Board of Nursing, PO Box 656, Jefferson City, Missouri 65102.

What is Public Information?

In accordance with Section 620.010(7), RSMo, the only information regarding an applicant/licensee that is public includes:

- Name
- Address
- License type, license number, dates of issuance and expiration date
- License status
- License certifications
- Disciplinary action taken against a license

The above information is the only information that may be released to the public, including family members, employers and the media.

Confidential information in an applicant/licensee's file may only be released under the following circumstances:

- With the written authorization of the applicant/licensee
- Through the course of voluntary interstate exchange of information with other boards of nursing
- Pursuant to a court order
- To other administrative or law enforcement agencies acting within the scope of their statutory authority

Occasionally, a caller might want to verify an applicant/licensee's date of birth or social security number. That information is not public information and therefore cannot be verified by our office unless we are provided with a signed release from the applicant/licensee.

Contacting the Board

In order to assist you with any questions and save both yourself and our office valuable time, please have the following information available when contacting the Board:

- License number
- Pen and paper

Summary of Actions June 2008 Board Meeting

Education Matters
Initial Approval

- *Initial approval was granted for Ozark Technical Community College, Associate Degree Nursing Program, #17-435.*

Full Approval

- *Full approval was granted for Lester L. Cox College of Nursing and Health Sciences BSN Program, Baccalaureate Degree Nursing Program #17-512.*

Curriculum Changes

- *Request for curriculum revisions was approved for Truman State University, Baccalaureate Degree Nursing Program #17-512*
- *Request for curriculum changes was approved for Central Methodist University Baccalaureate Degree Nursing Program #17-509.*
- *Request for curriculum changes was approved for Sanford Brown College/St. Charles, Associate Degree Nursing Program #17-421.*
- *Request for curriculum changes was approved for Sanford Brown College/St. Charles, Practical Nursing Program #17-104.*
- *Request for curriculum changes was approved for Poplar Bluff Technical Career Center, Practical Nursing Program #17-153.*
- *Request for curriculum changes was approved for St. Louis University, Baccalaureate Degree Nursing Program #17-588.*
- *Request for curriculum changes was approved for Lester L. Cox College of Nursing and Health Sciences, Associate Degree Program #17-425.*
- *Request for curriculum changes was approved for Lester L. Cox College of Nursing and Health Sciences, Baccalaureate Degree Program #17-512.*

Admission Revisions

- *Request for changes in admission was approved for College of Nursing at the University of St. Louis, Baccalaureate Degree Nursing Program #17-506.*
- *Request for changes in admission was approved for Pemiscot County Vocational School of Practical Nursing, Practical Nursing Program #17-143.*

Enrollment Changes

- *Request to increase enrollment from 80 students once a year to 60 students twice a year in January and August at Missouri State University/West Plains, Associate Degree Nursing Program #17-400 was approved*

Surveys

- *Numerous survey reports were reviewed and accepted.*

Discipline Matters

The Board held 13 disciplinary hearings and 20 violation hearings.

Licensure Matters

The Licensure Committee reviewed 50 cases. Results of reviews as follows:

Applications Approved—15
Applications Approved with letters of concern—10
Applications Approved with censure—1
Applications Approved with probated licenses—10
No further action taken—2
Applications tabled for additional information—2
Applications Denied—10

DISCIPLINARY ACTIONS**

Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

***Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number.*

PROBATIONARY LICENSE

Listed below are individuals who were issued an initial probationary license or had their expired or inactive licenses renewed on a probationary status by the Board during the previous quarter with a brief description of their conduct.

Name	License Number	Violation	Effective Dates of Restricted License
Thomas Chad Beckley Carl Junction MO	**RN2008013291**	On July 30, 2007, Licensee checked into an addiction recovery center. Licensee was discharged on November 16, 2007. While at the center, Licensee was diagnosed as having an alcohol and opiates dependence. Licensee admitted that he had been abusing drugs and alcohol for several years. During Licensee's treatment at the center, Licensee also enrolled with the Louisiana State Board of Nursing's Recovering Nurse Program.	5/19/2008 to 5/19/2010
Robert Edward Berry Lake City AR	**RN2008009970**	Licensee successfully passed the licensure examination and was issued a probated license. On May 28, 1992, Licensee pled guilty to the felony offenses of Burglary and Theft. The Court placed Licensee on five years of supervised probation for the Theft conviction. Licensee successfully completed that period of probation. The Court suspended imposition of sentence on the Burglary charge for a period of three years. Licensee completed that period of probation and was, subsequently, not convicted of that offense. In March of 1996, Licensee pled guilty to the offense of Passing a Bad Check. The Court sentenced Licensee to three years of probation. Licensee successfully completed that period of probation. On August 15, 2006, Licensee pled guilty to the Class C Felony of Passing a Bad Check. The Court placed Licensee on five years of supervised probation. Licensee is still under the Court's probation order.	4/8/2008 to 4/8/2010
Paul B Davies Fulton MO	**RN145526**	On February, 2003, Licensee pled guilty to driving while intoxicated. The Court suspended imposition of sentence and placed Licensee on three years probation. On June 8, 2005, Licensee pled guilty to driving while intoxicated and leaving the scene of an accident. The Court ordered Licensee to pay a fine and serve two hundred and thirty days in jail. Half of the fine and one hundred and eighty days of the jail sentence were suspended and Licensee was placed on five years of probation.	5/15/2008 to 5/15/2010
Lisa K Pellham Wasola MO	**RN122329**	In January 2000, Licensee misappropriated Fentanyl from her employer for her personal consumption. Prior to misappropriating Fentanyl, Licensee had misappropriated Demerol and IV Morphine for her personal consumption. Fentanyl, Demerol and Morphine are controlled substances. Licensee did not have a valid prescription for Fentanyl, Demerol or Morphine. Licensee sought chemical dependency treatment and returned to her nursing duties. Within one month of returning to work, Licensee was allowed to administer narcotics again. In June/July 2000, Licensee relapsed and misappropriated narcotics from her employer for her personal consumption. Licensee sought chemical dependency treatment. In 2002, following treatment, Licensee voluntarily surrendered her nursing license rather than complete the chemical dependency treatment recommended by the Board.	4/18/2008 to 4/18/2013

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The Board of Nursing is requesting contact from the following individuals:

Carla Santee—RN 134924
Michelle Burch—RN 200162362
Teresa King—PN 043160
Daren Cartwright—PN 058009
Gladys Warrior—PN 055206
Troy Hobbs—RN2001022470

If anyone has knowledge of their whereabouts, please contact Beth at 573-751-0082 or send an email to nursing@pr.mo.gov

Number of Nurses Currently Licensed in the State of Missouri

As of July 31, 2008

Profession	Number
Licensed Practical Nurse	22,543
Registered Professional Nurse	89,347
Total	**111,890**

Schedule of Board Meeting Dates Through 2009

September 10-12, 2008
December 3-5, 2008
March 11-13, 2009
June 3-5, 2009
September 9-11, 2009
December 2-4, 2009

Meeting locations may vary. For current information please view notices on our website at http://pr.mo.gov or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at http://pr.mo.gov

13th Annual Bi-State Regional Infectious Disease Conference

The Thirteenth Annual Bi-State Regional Infectious Disease Conference is Friday October 10, 2008, at the St. Louis Hilton Airport. Keynote speaker is from the CDC on MRSA/VRSA and other hot topics such as Effectiveness of Flu Vaccine, Bloodstream Infections, Occupational Medicine r/t Body Substances, STD in Correctional facilities and more. Speakers are nationally known and local experts in their field.

Visit www.bistateidconference.org or contact Pat Giacin at pgiacin@touchette.org. Conference cost $85.00 includes continental breakfast and lunch, handouts, CEU's, exhibits and parking.

Disciplinary Actions cont. from page 10

CENSURE

Name	License Number	Violation	Effective Dates of Censured License
Lucretia L Allen Ravenwood MO	**RN133518**	Licensee documented that she had received a physician's order and had read back and verified the order with the physician, when, in actuality, the conversation never took place.	4/10/2008 to 4/11/2008
Mary Catherine Arnold Battlefield MO	**RN2000167707**	Licensee removed an external fetal monitor without a physician's order and without notifying the physician of her actions.	3/15/2008 to 3/16/2008
Carol J Bailey Higginsville MO	**PN048347**	Licensee initialed 43 medical records on March 4, 2007 during her shift. Upon discovering her mistake, she failed to correct the errors making it appear that she had checked physician order sheets when, in fact, she had not.	3/27/2008 to 3/28/2008
Rebecca S Barnett Gerald MO	**PN2002030431**	Licensee practiced nursing on a lapsed license from May 31, 2006-October 30, 2007.	3/15/2008 to 3/16/2008
Karen A Baybo Saint Louis MO	**PN050757**	Licensee accepted a loan from a resident. When the employer learned of the loan, licensee was terminated. Upon termination of licensee, the licensee returned the money to the resident.	4/26/2008 to 4/27/2008
Azsure N Delap Florissant MO	**RN2002031794**	Licensee failed to see her patients and return calls to them.	4/8/2008 to 4/9/2008
Carol F Hall Clinton MO	**PN050238**	Licensee practiced nursing while her license was lapsed.	5/13/2008 to 5/14/2008
Jamica Marie Kelly Columbia MO	**PN2006012904**	Licensee abandoned her work area. Licensee reported to work at 7:00 a.m., left the narcotic key at the nurse's station, did not leave a report and told no one that she was leaving. Licensee left the facility at 8:00 a.m.	5/29/2008 to 5/30/2008
Sherril W Mathis Lebanon MO	**RN069666**	Licensee was employed as a school nurse and failed to properly waste the medication left in the nurse's office at the end of the school year.	4/3/2008 to 4/4/2008
Susan M Miller Kansas City MO	**RN138373**	Licensee under discipline in the state of Kansas.	3/13/2008 to 3/14/2008
Elizabeth Marie Staab O Fallon MO	**RN2000149194**	Licensee plead guilty August 22, 2006 to a Class A misdemeanor of stealing and received an SIS and two years of supervised probation.	3/15/2008 to 3/16/2008
Doras L Trussell Moberly MO	**RN142709**	Licensee was the only charge nurse on duty and failed to chart a restraint incident at the Moberly Nursing and Rehabilitation Facility.	4/2/2008 to 4/3/2008
Judith Louise Williams Sikeston MO	**PN2002020020**	Licensee under discipline in the State of Arkansas.	3/13/2008 to 3/14/2008

PROBATION

Name	License Number	Violation	Effective Dates of Probation
Orisa Jean Babcock East Alton IL	**RN2002027533**	In January 2005, Licensee used marijuana. On January 24, 2005, an anonymous caller alleged that Licensee had used controlled substances. When confronted with the allegation, Licensee denied ever having used marijuana. On January 25, 2005, Licensee submitted to a urinalysis test. Licensee specimen tested positive for marijuana metabolites. Licensee had no valid prescription for marijuana or any other substance which would test positive for marijuana.	3/20/2008 to 3/20/2010
Kathleen M Bailey Saint Louis MO	**PN058448**	At all times relevant herein, Licensee was employed as a licensed practical nurse at a rehabilitation facility. During their shift on July 27, 2006, Licensee asked the other nurse if she could borrow her set of keys, which included a key to the medication room and medication cart, to use the bathroom. When the other nurse went to get her keys back from Licensee, she found her in the medication room, in the mediation cart. Licensee stated that she was borrowing Vicodin, because she was out of her prescription. The other nurse observed Licensee remove and consume two Vicodin tablets a resident's medication. Licensee withdrew pain medications for four residents on July 27, 2006. Residents were alert and oriented. Each resident stated that they had not requested pain medication on July 27, 2006, and that Licensee had not given them pain medication on that date. Licensee misappropriated the above-referenced medications for her personal consumption, resulting in her termination on July 28, 2006.	5/24/2008 to
Tracie Lynn Bliefert Moberly MO	**PN2005036429**	On August 4, 2006, Licensee submitted to a urine drug screening test as part of the pre-employment hiring process. The urine sample submitted tested positive for THC, a metabolite of marijuana.	3/11/2008 to 3/11/2010
Jaime Anne Bohannon Sedalia MO	**PN2004028901**	Pursuant to a Settlement Agreement, Licensee's license was placed on probation for a period of two (2) years. Pursuant to the Agreement, Licensee was required to abstain completely	3/19/2008 to 10/30/2011

Continued on Page 13

Disciplinary Actions cont. from page 12

Name	License Number	Violation	Effective Dates of Censured License
		from the use or possession of any controlled substance or other drug for which a prescription is required unless use of the drug has been prescribed by a person licensed to prescribe such drug and with whom Licensee has a bona fide relationship as a patient. On January 18, 2008, Licensee submitted a urine sample for random drug screening. That sample tested positive for the presence of marijuana. Marijuana is a controlled substance. Licensee did not have a valid prescription for marijuana. In accordance with the terms of the Agreement, Licensee is required to contract with NCPS, Inc. to schedule random drug and alcohol screenings. Pursuant to that contract, Licensee is required to call a toll free number every day to determine if she is required to submit to a test that day. During the disciplinary period, Licensee failed to call in to NCPS, Inc. on nine (9) days.	
Marylene L Brown Saint Louis MO	**PN028597**	Between May 27, 2004 and July 6, 2004, the patient was one of Licensee's patients. Between May 27, 2004 and July 4, 2004, the patient's temperature ranged from 96 degrees Fahrenheit to 100.7 degrees Fahrenheit. Between May 27, 2004 and July 4, 2004, the patient's phlegm remained white and frothy. At 9:00 a.m. on July 5, 2004, Licensee observed that the patient had a temperature of 104.6 degrees Fahrenheit and was producing thick, yellowish phlegm. The patient's 104.6 degree temperature and thick, yellowish phlegm collectively constituted a change in patient condition. Licensee did not notify the primary care physician or any physician that the patient had a 104.6 degree temperature and was producing thick, yellowish phlegm at 9:00 a.m. on July 5, 2004; instead, Licensee performed suctioning on the patient and administered Tylenol and ice packs. At 2:30 p.m. on July 5, 2004, Licensee observed that the patient's temperature was 103.7 degrees Fahrenheit. The patient's 103.7 degree temperature at 2:30 p.m. on July 5, 2004 constituted a continuing change in patient condition and a patient being non-responsive to previously administered treatment. Licensee did not notify the primary care physician or any physician of the 103.7 temperature at 2:30 p.m. on July 5, 2004, or of the fact that the patient was not responding to previously administered treatment. On July 6, 2004, the staff documented in the patient's chart that at 6:00 a.m. that day, the patient had a fixed stare. On July 6, 2004, at 9:00 a.m., Licensee observed that the patient had a temperature of 103.2 degrees Fahrenheit, had rapid respirations and had brown tinged phlegm. The patient's 103.2 degree temperature, rapid respirations, brown tinged phlegm and fixed stare collectively constituted a change in patient condition. Licensee did not notify the primary care physician or any physician that the patient had 103.2 degree temperature, rapid respirations, brown tinged phlegm and a fixed stare between 6:00 a.m. and 9:00 am on July 6, 2004; instead, Licensee only performed suctioning on the patient and administered Tylenol. On July 6, 2004, at 2:30 p.m., Licensee observed that the patient had a temperature of 103.1 degrees Fahrenheit. The patient's 103.1 degree temperature at 2:30 p.m. on July 6, 2004 constituted a continuing change in patient condition and a patient being non-responsive to previously administered treatment. Licensee did not notify the primary care physician or any physician that the patient had 103.1 degree temperature at 2:30 p.m. on July 6, 2004, or of the fact that the patient was not responding to previously administered treatment. On July 6, 2004, at 11:00 p.m., the patient died.	5/24/2008 to 5/24/2009
Holly Cagle Stover MO	**RN148475**	From October 2000 until January 2, 2002, Licensee was employed as a registered professional nurse at a skilled nursing facility. The Director of Nursing was the person at the skilled nursing facility designated to handle patient complaints. On December 30 and 31, 2001, and on January 1, 2002, Licensee was the charge nurse on the night shift, 11 p.m. to 7 a.m. Twelve of the residents under her care were diabetic. Licensee's duties included performing Accu checks on each diabetic at 6 a.m. The patients and the skilled nursing facility relied on Licensee to perform the Accu checks and to properly document the results in each resident's medical file. On December 31, 2001, two diabetic patients complained to a certified nursing assistant and to the other nurse that they had not gotten their 6 a.m. Accu checks before getting their insulin shots. Both patients were alert and aware of their surroundings. One of them recalled what her Accu check results were from the two Accu checks on the day before. On January 1, 2002, the other nurse reported to the Director of Nursing what the two residents had said. On January 1, 2002, the Director of Nursing had the other nurse ask each of the 12 diabetic residents under Licensee's care whether they could recall having an Accu check at 6 a.m. that morning. The other nurse reported that nine of the residents said they did not get their Accu check or they did not recall it; one said she or he did get the Accu check; one said he or she got the Accu check from the other nurse; and one did not answer. Licensee was the night charge nurse on duty for the 6 a.m. Accu check for January 2, 2002. Licensee intentionally skipped doing the 6 a.m. Accu checks for the 12 diabetic residents under her care. Instead, Licensee wrote false blood glucose levels on the diabetic flow sheets for those residents, as if she had performed the Accu checks. After Licensee wrote the blood glucose levels on the diabetic flow	3/20/2008 to 3/20/2009

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Disciplinary Actions cont. from page 13

Name	License Number	Violation	Effective Dates of Censured License
		sheets, the Director of Nursing brought the Glucometer from Licensee's nurses' station to her office along with the diabetic flow sheets. The Director of Nursing activated a display of the Glucometer's memory. The Glucometer did not show blood glucose levels that matched those that Licensee had written in the diabetic flow sheets for 6 a.m., January 2, 2002. The Director of Nursing terminated Licensee on January 2, 2002.	
Diane M Carroll O Fallon MO	**RN098214**	On October 1, 2007, Licensee arrived to work with a strong odor of alcohol and slurred speech. Licensee stated that she had something to drink at 1:00 a.m. on October 1, 2007. Licensee was also on-call from 11:00 pm. September 31, 2007 until 7:00 a.m. October 1, 2007. The Nurse Manager asked Licensee to submit to a for cause drug test however Licensee refused. Licensee was terminated on October 5, 2007.	5/28/2008 to 5/28/2011
Christy J Chaney Willow Springs MO	**RN110260**	In March 2004, Licensee attended a meeting with the Vice President and Chief Nursing Officer in which Licensee informed the Vice President and Chief Nursing Officer that Licensee had an alcohol dependency problem and requested a leave of absence in order to seek treatment. During the March 2004 meeting, the Vice President and Chief Nursing Officer approved Licensee's request for leave. Licensee's outpatient chemical dependency treatment was to begin in April 2004, and Licensee agreed to return to work on May 1, 2004. On May 3, 2004, Licensee again met with the Vice President and Chief Nursing Officer and signed a "sobriety contract" with them as a condition of returning to work. During the May 3, 2004 meeting, Licensee requested an additional two weeks of leave, until May 17, 2004, before returning to work. Licensee made this request at the advice of an addiction outpatient psychiatrist. The Vice President and Chief Nursing Officer agreed to Licensee's request. During the interval between May 3, 2004 and May 17, 2004, Licensee relapsed and entered detoxification treatment Licensee was released from treatment during the first week of June 2004, and relapsed within one week. The Vice President and Chief Nursing Officer allowed Licensee to continue on leave while Licensee sought additional treatment for alcohol dependency. Licensee returned to work on June 20, 2004. On June 28, 2004, at approximately 10:00 a.m., Licensee left her employment. At the time she left, Licensee informed a fellow nurse that Licensee would be available by pager if needed. On June 28, 2004, after leaving her employment at 10:00 a.m., Licensee eventually returned home and began drinking. Later on June 28, 2004, Licensee was found in her home in a nearly unresponsive state. Police and/or paramedics transported Licensee to the Emergency Room. Upon arrival at the emergency room, Licensee's blood alcohol registered at 0.487 percent. Licensee's use of alcohol after leaving work at 10:00 a.m. on June 28, 2004 constituted a breach of the sobriety contract she entered into on May 3, 2004. On June 30, 2004, Licensee's employment was terminated.	4/19/2008 to 4/19/2011
Robyn Ann Coleman Columbia MO	**PN2006035280**	On May 7, 2007, Licensee pled guilty to a Class C Felony, Possession of a Controlled Substance. On July 23, 2007, Licensee was terminated due to her felony conviction.	5/1/2008 to 5/1/2013
Jennifer Georgene Crockarell West Plains MO	**RN2000163404**	On July 23, 2007, the Home Health Manager received an anonymous telephone call stating that Licensee had used Methamphetamines the prior week end. On the afternoon of July 24, 2007, the Home Health Manager confronted Licensee regarding the allegations and Licensee denied taking Methamphetamines and volunteered to submit to a drug screen. The results of the drug screen was positive for Methamphetamines and on July 27, 2007, per the facilities policy, Licensee was referred to Behavioral Health Services to be evaluated by a mental health professional. The mental health professional stated that Licensee could return to work, but Licensee had to submit to random drug testing over the next year. Licensee was placed in her position with the stipulation that Licensee had to take random drug tests for one year.	4/26/2008 to 4/26/2011
Brian C Denmark, Sr Granby MO	**RN147399**	Licensee was required to contract with NCPS, Inc. to schedule random drug and alcohol screenings. Pursuant to that contract, Licensee is required to call a toll free number every day to determine if he is required to submit to a test that day. During his probation, Licensee failed to call in to NCPS, Inc. on nineteen (19) days. Further, on November 13, 2007 and December 4, 2007, Licensee called NCPS, Inc. and was advised that he had been selected to provide a urine sample for screening. Licensee failed to report to a laboratory to provide a sample. Pursuant to the terms of Licensee's probation, Licensee was to submit an employer evaluation from every employer or, if Licensee was unemployed, a notarized statement indicating the periods of unemployment. Licensee failed to submit an employer evaluation by the January 1, 2008 due date. In accordance with Licensee's probation, Licensee was to submit evidence of weekly (or recommended) attendance at AA, NA or other support group meetings. Licensee failed to submit evidence of attendance at support group meetings by the January 1, 2008 due date.	3/20/2008 to 7/21/2011

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Name	License Number	Violation	Effective Dates of Probation
Mavis A Epting Saint Louis MO	**PN034014**	Between May 27, 2004 and July 6, 2004, the patient was one of Licensee's patients. Between May 27, 2004 and July 4, 2004, the patient's temperature ranged from 96 degrees Fahrenheit to 100.7 degrees Fahrenheit. Between May 27, 2004 and July 4, 2004, the patient's phlegm remained white and frothy. At 9:00 a.m. on July 5, 2004, Licensee observed that the patient had a temperature of 104.6 degrees Fahrenheit and was producing thick, yellowish phlegm. The patient's 104.6 degree temperature and thick, yellowish phlegm collectively constituted a change in patient condition. Licensee did not notify the primary care physician or any physician that the patient had a 104.6 degree temperature and was producing thick, yellowish phlegm at 9:00 a.m. on July 5, 2004; instead, Licensee performed suctioning on the patient and administered Tylenol and ice packs. At 2:30 p.m. on July 5, 2004, Licensee observed that the patient's temperature was 103.7 degrees Fahrenheit. The patient's 103.7 degree temperature at 2:30 p.m. on July 5, 2004 constituted a continuing change in patient condition and a patient being non-responsive to previously administered treatment. Licensee did not notify the primary care physician or any physician of the 103.7 temperature at 2:30 p.m. on July 5, 2004, or of the fact that the patient was not responding to previously administered treatment. On July 6, 2004, the staff documented in the patient's chart that at 6:00 a.m. that day, the patient had a fixed stare. On July 6, 2004, at 9:00 a.m., Licensee observed that the patient had a temperature of 103.2 degrees Fahrenheit, had rapid respirations and had brown tinged phlegm. The patient's 103.2 degree temperature, rapid respirations, brown tinged phlegm, and fixed stare collectively constituted a change in patient condition. Licensee did not notify the primary care physician or any physician that the patient had 103.2 degree temperature, rapid respirations, brown tinged phlegm and a fixed stare between 6:00 a.m. and 9:00 am on July 6, 2004; instead, Licensee only performed suctioning on the patient and administered Tylenol. On July 6, 2004, at 2:30 p.m., Licensee observed that the patient had a temperature of 103.1 degrees Fahrenheit. The patient's 103.1 degree temperature at 2:30 p.m. on July 6, 2004 constituted a continuing change in patient condition and a patient being non-responsive to previously administered treatment. Licensee did not notify the primary care physician or any physician that the patient had 103.1 degree temperature at 2:30 p.m. on July 6, 2004, or of the fact that the patient was not responding to previously administered treatment. On July 6, 2004, at 11:00 p.m., the patient died.	3/19/2008 to 3/19/2009
Amy J Gandy Galena KS	**RN129118**	The Director of Maternal/Child Services at a hospital stated that around August of 2006 several staff members observed Licensee falling asleep while on duty and that Licensee's performance was quickly diminishing. Licensee's performance issues continued throughout the winter months of 2006 and Licensee stated that she was having a lot of personal problems and she was taking anti-depressants which made her sleepy. The Director of Maternal/Child Services began monitoring Licensee's Pyxis reports and she noticed a lot of discrepancies in Licensee's December Pyxis report. The discrepancies were with regard to Sufenta, the amount of Sufenta the Licensee had pulled out of the Pyxis was different then what Licensee had documented that she had given to patients. There were also several instances when Licensee had pulled drugs for patients that were not under her care, for patients whose pain had been charted as zero or for patients who had already delivered. The Director of Maternal/Child Services monitored Licensee's reports until mid January of 2007 and she found discrepancies of over 16 vials of Sufenta. In January of 2007, the Director of Maternal/Child Services confronted Licensee and Licensee admitted to diverting Sufenta for her personal use.	4/26/2008 to 4/26/2011
Lana L Harlan Columbia MO	**RN145091**	On May 20, 2005 Licensee accepted a position which required a drug screen. As a result, License voluntarily submitted a urine sample which was sent to the Toxicology and Drug Monitoring Laboratory. On May 20, 2005, Licensee's urine specimen tested positive for cocaine. Licensee has no valid prescription for any compound which would result in a positive drug screen for cocaine.	3/20/2008 to 3/20/2011
Dawn A Hassinger Sikeston MO	**RN140350**	The Licensee's nurse manager stated that multiple complaints were received from a patient's daughter regarding Licensee. The Cardiac Clinic Coordinator stated that when the patient arrived at the facility the physician wrote orders for a Cardizem drip however there was a three hour delay before Licensee started the Cardizem drip. Licensee failed to document at what dose or rate the Cardizem drip was infusing. Licensee also failed to document vital signs for the patient in accordance with Policy. According to the facility policy vital sign are to be taken and documented every fifteen minutes when a drip is started; however Licensee only documented vital signs for when the drip was hung and no vital signs were documented for the next hour. The Cardiac Clinic Coordinator stated that Licensee told her that she had adjusted the patient's drip however Licensee had not documented any vital signs when she adjusted the patient's drip. The patient also had an order to start a Cordarone drip if the Cardizem drip failed to bring the heart rate down in a reasonable amount of time; however Licensee failed to start the second drip as the physician's order	4/19/2008 to 4/19/2010

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Name	License Number	Violation	Effective Dates of Probation
		had indicated. At 10:00 p.m. on March 22, 2007 Licensee called the patient's physician however the call was not documented. According to the Cardiac Clinic Coordinator there was an order by the physician to move the patient to ICU however Licensee did not document the transfer. The Cardiac Clinic Coordinator also stated that Licensee failed to document that the patient had arrived at the facility with Total Parenteral Nutrition infusing; however Licensee failed to document this information. The Cardiac Clinic Coordinator stated that the patient's daughter had complained that there was a delay in receiving the patient's pain medication. On March 26, 2007 Respondent was terminated due to not meeting job standards.	
Natasha Jean Hernandez Fulton MO	**PN2004027753**	On October 15, 2005, Licensee gave a client who had a history of self-harm and was on suicide precaution his Accu-Check machine and all of his lancets. The client was permitted to conduct his own finger sticks using his lancets and his own Accu-Check machine; however the client was not permitted to have the Accu-Check machine and all of the lancets at one time. The client reported that he had swallowed the lancets and he was taken to a hospital where an x-ray revealed that he had swallowed the lancets. As a result of the incident, a preliminary determination of one count of Class II Neglect was made against Licensee by the Missouri Department of Mental Health.	4/19/2008 to 4/19/2010
Grace E Herring Joplin MO	**RN135051**	On December 25, 2004, during her shift, Licensee received a physician's order to administer Glucophage to one of her patients. At the time Licensee received the physician's order, her patient was not eating. As a result, Licensee did not administer Glucophage until her patient began eating, which was approximately three hours after Licensee received the physician's order. Licensee had duty to promptly administer all medications prescribed by physicians. On December 25, 2004, Licensee failed to accurately and effectively chart and/or record the administration or disposal of controlled substances.	3/20/2008 to 3/20/2009
Robert W Howe Kansas City MO	**RN098290**	During his employment as a registered professional nurse, Licensee diverted Demerol for his personal consumption in 2005. Licensee consumed the Demerol he diverted. Licensee did not hold a prescription for Demerol at all relevant times herein.	4/18/2008 to 4/18/2013
William Timothy Huggins Warrenton MO	**PN2006024238**	Licensee was required to meet with representatives of the Board at such times and places as required by the Board. Licensee was advised, by certified mail, to attend a meeting with the Board's representative on January 2, 2008. Licensee failed to attend the meeting, but did call and verbally reschedule the meeting for January 9, 2008. Licensee did not attend the January 9, 2008 meeting and did not contact the Board to reschedule. Pursuant to the terms of Licensee's probation, Licensee was required to undergo a thorough mental health evaluation within six (6) weeks of the effective date of the Order and have the results sent to the Board. The evaluation was due by January 23, 2008. The Board never received a thorough mental health evaluation submitted on Licensee's behalf.	3/19/2008 to 3/19/2010
Denette C Jahnsen Robertsville MO	**RN076590**	On August 12, 2004, while on duty, Licensee tested positive for amphetamine, for which she had no valid prescription.	4/16/2008 to 4/16/2010
Mary V Johnson Saint Louis MO	**RN078009**	On July 19, 2007, Licensee applied for a position with a temporary agency and as part of the hiring process she was asked to submit to a drug screen. Licensee drug screen showed positive for Propoxyphene, Benzodiazapine and undefined for cocaine. Licensee was asked to go to Urgent Care for additional testing. On July 26, 2007, the temporary agency received the results from Urgent Care which showed that Licensee tested positive for Propoxyphene and Cocaine. Licensee was not offered a position.	4/19/2008 to 4/19/2013
Kimberly S Kennon Cape Girardeau MO	**RN103388**	Licensee is required to abstain completely from the use or consumption of alcohol. On August 24, 2007 and January 10, 2008, Licensee submitted urine samples for random drug and alcohol screening. The samples tested positive for the presence of ethyl glucuronide, a metabolite of alcohol.	3/20/2008 to 6/18/2012
Jason Matthew Klint Lees Summit MO	**RN2002007365**	On September 12, 2002 until November 28, 2004, Licensee worked as a registered professional nurse for a staffing agency. On the morning of November 28, 2004, Licensee was placed in the post-surgical recovery room of a hospital. On the morning of November 28, 2004, at about 9:30 a.m., Licensee was assigned to care for a patient. The patient was Licensee's only patient that morning. The patient was recovering from surgery to correct a fractured fibula (a broken ankle). Following the patient's surgery, the primary care provider ordered fifty (50) milligrams of Demerol to be administered intramuscularly and twenty-five (25) milligrams of Vistaril to be administered intramuscularly in the recovery room. Licensee withdrew and documented the intramuscular administration of fifty (50) milligrams of Demerol and twenty-five (25) milligrams of Vistaril at about 9:30 a.m. Following the aforementioned administration of Demerol and Vistaril, Licensee contacted the doctor and informed the doctor that the patient was still in pain. The primary care provider verbally ordered an additional fifty (50) milligrams of Demerol to be administered intravenously to the patient. Licensee withdrew	4/2/2008 to 4/2/2009

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Name	License Number	Violation	Effective Dates of Probation
		and documented the intravenous administration of the aforementioned Demerol at about 9:35 a.m. On the morning of November 28, 2004, Licensee withdrew a total of three hundred (300) milligrams of Demerol for the patient. Licensee documented the administration or disposal of only two hundred fifty (250) milligrams of Demerol. Licensee failed to document the administration or disposal of fifty (50) milligrams of Demerol.	
Mary Alice Krueger Springfield MO	**RN137024**	In May 2006, a resident at the facility had a physician's order order for the administration of one dose of Actonel each week. On Friday, May 12, 2006, Licensee mistakenly administered a second dose of Actonel to the resident. Licensee properly documented and reported the medication error on the patient's chart. On May 23, 2006, Licensee was assigned to care for another resident whose physician had ordered a critical PT and INR to be drawn during the morning hours of May 23, 2006. PT and INR (PT/INR) tests evaluate the ability of blood to clot properly. Licensee failed to follow physician orders, in that she failed to draw blood from the resident during the morning hours of May 23, 2006 as ordered by the physician. On June 7, 2006, Licensee administered Systane to a resident without confirming receipt of a physician order's to do. On June 9, 2006, a resident assigned to Licensee had physician orders for the administration of 30 mg. of Oxycodone every four hours. Licensee withdrew and administered the 12:00 a.m. dose, but failed to administer the 4 a.m. dose. A narcotic count the following morning showed that the 4:00 a.m. dose was still in place and had not been withdrawn.	3/14/2008 to 6/13/2008
Julie L Lansford Jefferson City MO	**PN056492**	On several occasions Licensee was seen while at work on the phone with a patient in the facility. It was found that Licensee has given her cell phone number to the patient, had exchanged love letters and a greeting card with the patient and mailed him a phone card. An investigation was completed and resulted in findings of one count of Sexual Abuse and two counts of Class II Neglect against Licensee. Initially Licensee denied the allegations however she later admitted to exchanging phone calls and love letters with the patient as well as sending the patient a phone card.	4/19/2008 to 4/19/2009
Tina A Mathews Trenton MO	**PN046724**	On June 2, 2004, a Resident has been diagnosed with Alzheimer's dementia, with verbal and physical aggressive behaviors and anxiety. The Resident's care plan addressed behaviors of aggression, agitation, anger at staff and restlessness. The Staff were instructed to approach the Resident in a non-threatening manner and to ask another staff person for assistance. On June 2, 2004, the Resident was wandering up and down hallways and opening doors. Licensee approached the Resident in a threatening manner, took off her glasses and generally acted like Licensee was preparing for a physical fight with the Resident. Licensee told the Resident she should, "knock him on his ass and put him in his place." Licensee then looped her arm through the Resident's arm, turned the Resident around and dragged him down the hall and into his room where Licensee forcefully pushed the Resident down into his recliner.	4/17/2008 to 4/17/2011
Vicki Sue McGinnis Kansas City KS	**PN2001003259**	From June of 2003 until April 14, 2005, Licensee worked as a licensed practical nurse for a home health care services. Licensee worked as a home health care nurse. On March 8, 2005, Licensee was assigned to provide home nursing case for a client. At the time of the events alleged herein, the client was an 18 month old girl with aicardi syndrome, seizure disorder, and severe scoliosis. The client required twenty-four (24) hour per day, seven (7) day per week supervision and care for ventilator support. Licensee was aware of the supervision requirements and her duty to continually observe and monitor the client's condition. While on duty, Licensee fell asleep at the client's home without other adults present to supervise or monitor the client. While Licensee slept, liquid accumulated in the client's ventilator tubing to such an extent that it prevented the flow of oxygen to the client. Licensee failed to awaken when the alarms of the client's ventilator and monitoring equipment sounded. The client's blood oxygen level fell to forty (40) percent, her lips turned blue and she struggled to breathe while Licensee slept. The daughter's father arrived home to find the daughter's alarms sounding and Licensee asleep. The daughter's father disconnected his daughter's ventilator, drain her ventilator tubing and provide respiratory resuscitation to his daughter himself.	5/24/2008 to 5/24/2010
Sharon G McNelly Vichy MO	**PN034569**	Licensee's Missouri nursing license was originally issued on or about December 15, 1983. Licensee's license lapsed on June 1, 2000. Licensee has continuously practiced as a licensed practical nurse in Missouri since her license expired.	3/13/2008 to 3/13/2009
Michelle Diane Medlock New Madrid MO	**PN2000170568**	On June 3, 2007, Licensee was responsible for a patient in the end stages of the disease process and assigned "compassionate care" only. Patient was in soft cloth hand restraints because the patient was pulling at their Nasal Gastric Tube and IV. This patient had a feeding tube, a catheter and an IV. Hospital policy for patients in restraints includes monitoring the patient every hour. On each hourly check, the restraints had to be released, the patient's arms had to be moved, the patient had to be repositioned and then the restraints had to be put back in place if the patient continued to pull at the tubes. The patient passed away at 3:25 a.m. on June 3, 2007. Licensee pre-documented on the patient's chart that the required hourly	5/28/2008 to 5/28/2009

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Name	License Number	Violation	Effective Dates of Probation
		checks and procedures were followed throughout the night up until 7:00 a.m., even though the patient had passed away 3 ½ hours earlier. Licensee pre- documented the patient's vitals for her entire shift.	
Jerry E Meredith Ozark MO	**PN057811**	As a staff nurse, Licensee was responsible for the appropriate care and treatment of his patients, many of which suffered from behavioral disorders. The hospital's policy for nurses caring for patients who exhibit behavioral problems requires that nurses never mistreat or hurt their patients. On December 31, 2004, one of Licensee's patients was being loud past bedtime. When the patient refused to be quiet, Licensee was observed grabbing the patient by the arm and dragging the patient across the room for "time out." While on the way to "time out," the patient fell to the floor, but Licensee continued to grab the patient's arm while dragging the patient to "time out." Licensee's conduct on December 31, 2004, violated the hospital's policy for the appropriate treatment of patients. On January 30, 2005, Licensee was assigned to Unit 2. The nurse on duty observed Licensee pull one of his patients across the room by his right ear. Once Licensee realized the nurse could see him, Licensee immediately stopped. According to the nurse, the patient's ear was "slightly swollen" as a result of Licensee's actions. On January 30, 2005, while working in the Unit, the nurse observed Licensee pull and twist another patient's arm above his head. Again, once Licensee realized the nurse could see him, Licensee immediately stopped. Licensee's conduct on January 30, 2005, violated the hospital's policy for the appropriate treatment of patients. As a result, the nurse prepared and reported an Incident Report to his supervisor.	3/11/2008 to 3/14/2008
Shannon Theresa Moore Saint Peters MO	**RN2001033462**	On March 6, 2005, Licensee was assigned to provide medication to a patient. The patient's treating physician ordered one, five milligram ("mg") tablet of Ativan to be administered to the patient once every four hours beginning at 10:00 a.m. At or about 9:36 a.m., Licensee withdrew six tablets of Ativan for the patient. On February 3, 2005, a patient was prescribed an elixir containing Tylenol with codeine for pain management following a thyroidectomy procedure. The patient's prescribed elixir of Tylenol with codeine were contained in a 15 milliliter ("ml") plastic bottle. Another nurse withdrew two bottles of the elixir for the patient. The patient was discharged on February 4, 2005. The patient's used only one full bottle of the elixir containing Tylenol with codeine. When Licensee arrived on her shift, she discovered the unused bottle of Tylenol with codeine in the medication cart. Licensee attempted to return the bottle containing Tylenol with codeine to the pyxis machine. Because of the size and shape of the elixir bottle, Licensee was unable to place the elixir bottle in the pyxis's medication return box. Licensee was told by one of the pharmacy technicians to maintain possession of the bottle until a pharmacy technician was able to retrieve it. While using the lavatory, Licensee left the elixir bottle and its contents unattended and accessible on the staff's lounge table. Licensee then failed to retrieve the elixir bottle and its contents when she left the lavatory. Later in the day, when Licensee was asked by the pharmacy technician for the unused contents of the bottle, Licensee was unable to immediately locate the bottle. Licensee eventually located the bottle in the staff lounge waste basket. The bottle which Licensee recovered contained no elixir in it; and said elixir was never recovered or accounted for. On July 16, 2004, Licensee was assigned to observe and treat a patient. On July 16, 2004, the patient had a peripherally inserted central catheter line in the patient's right arm. During a routine observation of the patient, Licensee noted that the patient's picc line was swollen (edematous) and appearing to contain an unusually large amount of fluid. Despite the patient's observation of the patient's edematous picc line, Licensee failed to report her observations to the patient's treating physician and/or "picc hotline."	3/11/2008 to 3/11/2009
Glenda D Newby Carterville MO	**PN027501**	On October 27, 2003, Licensee reported to her supervisor that one of the infants she was caring for in the NICU was driving her crazy. In the context of a conversation with her supervisor requesting reassignment from the infant, Licensee made a statement to the effect that Licensee was afraid she might hurt the patient if she was assigned to care for the infant. Licensee was removed from caring for the infant immediately following her conversation with her supervisor. In February 2004, Licensee was assigned to care for an infant in the NICU. The infant was born between 23 and 25 weeks gestation with a birth weight of 576 grams. At the beginning of February 2004, the infant weighed approximately five-and-a-half pounds, and had severe difficulties with lung function along with other medical problems frequently associated with preterm infants. To facilitate lung development and alleviate other medical conditions, the infant was given Decadron and steroids at various times in February 2004. Possible side-effects and complications resulting from using Decadron and steroids, as well as the infant's medical condition in February 2004 required her to be treated very gently, and handled minimally to reduce stress and facilitate growth and development. On February 5, 2004, Licensee was "patting" the infant on the diaper area while rocking her. A parent who observed Licensee's rocking the	5/1/2008 to 5/1/2010

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Name	License Number	Violation	Effective Dates of Probation
		infant reported to a nurse on the following shift that Licensee was patting the bottom of the infant and rocking the infant too forcefully. Licensee's employment was terminated as of February 13, 2004.	
Mark Allen Nolen Kennett MO	**PN2003019170**	Beginning in February 2004, Licensee began diverting Demerol from his employer for his personal use. Specifically, Licensee signed out Demerol for patients who had physician orders for Demerol, then falsely documented that he had administered the Demerol to the patient. Licensee then took the Demerol home and injected it himself. Licensee typically diverted 100 milligrams of Demerol per week during this period. On March 1, 2004, Licensee was hospitalized. While hospitalized, Licensee submitted a urine screen which tested positive for benzodiazepines, opiates and marijuana. On April 5, 2004, Licensee's employment was terminated. Beginning in July 2004, Licensee diverted 250 milligrams to 300 milligrams per day of Demerol, Dilaudid and Morphine for his personal use. Specifically, Licensee would submit physician orders for the narcotics to a pharmacy. When the pharmacy filled the prescription, Licensee kept the narcotics for his personal use. On October 18, 2004, Licensee took a medical leave of absence from his employer in order to receive drug treatment. Licensee's wife informed the staff that Licensee was addicted to narcotics and was receiving treatment for drug abuse. Between the dates of October 18, 2004 and November 18, 2004, inclusive, Licensee submitted several verbal prescription orders for Demerol to a pharmacy, using the name of a physician as the prescribing physician. Specifically, Licensee submitted orders for Demerol for two patients. At the time of the events described above, Licensee was still on leave of absence from his employer and was not authorized to order or pick up prescriptions for any of his employer patients. At the time of the events described above, the physician had not ordered Demerol for the two patients. On November 18, 2004, Licensee went to the pharmacy and picked up an order for injectable Demerol that he had ordered on behalf of one of his patients. After receiving the prescription for Demerol from the pharmacy, Licensee diverted the Demerol for his personal consumption. As a result of the conduct described above, Licensee's employment was terminated effective November 18, 2004. On December 2, 2004, Licensee was again hospitalized. At this time, Licensee admitted that he had used Demerol, Dilaudid, Morphine and Methadone on a daily basis for the prior three months. At the time of the conduct described herein, Licensee did not possess a valid script for Demerol, Dilaudid, Marijuana and Morphine.	4/16/2008 to 4/18/2013
Elizabeth M Quinton Bonne Terre MO	**RN2001019178**	At all times relevant herein, Licensee was employed as a registered professional nurse at a correctional center. Staff at the correctional center noticed inappropriate behavior between Licensee and an Inmate. Licensee and the Inmate were observed whispering and very secretive at times. On May 19, 2007, a co-worker was going to the office area to heat up her lunch. On her way to the office, she decided to go into the supply room to talk to Licensee. Upon entering the supply room, she observed Licensee and the Inmate in a romantic embrace and kissing. Licensee followed the co-worker out of the supply room and asked the co-worker not to report what she saw, or at least give her the opportunity to put in her two weeks notice, so she could continue working until her resignation became effective.	5/24/2008 to 5/24/2009
Christina Lee Reed Kansas City MO	**RN2005019765**	On June 22, 2007, Licensee was selected for random urine screening by the hospital. That screening showed positive for alcohol. Licensee entered into a contract with the hospital concerning her continued employment with the hospital. The contract stated that any future positive screenings would result in immediate termination. On October 5, 2007, Licensee was selected for random urine screening. That screening showed positive for alcohol. Licensee was terminated by the hospital.	5/14/2008 to 5/14/2011
Stephanie L Reed California MO	**PN2007006167**	On the morning of September 19, 2007, Licensee was seeing individuals who had requested medical attention. A patient requested medical attention concerning right knee pain due to a fall in the shower the night before. Licensee documented that she performed an assessment of the patient. The patient was scheduled for warm, moist heat to the back. Licensee documented that she applied the heat pack as ordered. At 11:15 p.m. the patient declared a medical emergency complaining of right leg pain and was transported to the Emergency Room via ambulance. Upon review of a videotape, it was found that Licensee spoke with the patient through a hole in the cell door while the patient was on his bunk. Licensee did not enter the cell or have the patient brought out of the cell or have any other physical contact with the patient. Licensee did not perform a physical assessment or provide prescribed treatment to the patient as she had documented.	5/31/2008 to 5/31/2009
Audria Michelle Reilly Independence MO	**PN2004005129**	On June 16, 2006, a resident, who was 85 years of age, was taken out of the facility by her family for several hours. The resident was at a high risk for stroke because her physician had recently taken her off Coumadin, because of complications from the drug. When the family returned the resident to the facility at approximately 4:15 on June 16, 2006, they reported	5/8/2008 to 5/8/2010

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Name	License Number	Violation	Effective Dates of Probation
		to nursing staff, including Licensee, that the resident had exhibited several minutes of difficulty feeding herself, dropping utensils and speech difficulty. They also informed Licensee that the resident had complained of her right hand and arm going to sleep. The family requested that the doctor be notified. Licensee stated that she would notify the physician. Licensee failed to immediately page the doctor, did not document anything in the resident's chart and did not take any vital signs from the resident. Licensee faxed the information to the physician, but failed to attempt to call, or page the physician. The physician was out of the office on Friday, June 16 through Sunday, June 18, 2006. On Monday morning, June 19, the resident was found unresponsive by an aide at 0705. The resident suffered a stroke and was transferred to a hospital and died on June 23, 2006. A review of the patient's chart revealed that there were no nurse's notes from June 16 through June 18, 2006.	
Karen E Rhine Joplin MO	**RN2000170582**	On 2/20/06, Licensee had a grand mal seizure at the nurse's desk after working a full night shift. Licensee admitted to stealing the Demerol and injecting it herself. Licensee stated to hospital staff that she took Demerol every night that she worked and during this last shift, she would go into the bathroom in the ICU and inject the drug.	4/27/2008 to 4/27/2013
Verneal S Rodgers Excelsior Springs MO	**PN058130**	On June 16, 2006, a resident, who was 85 years of age, was taken out of the facility by her family for several hours. The resident was at a high risk for stroke because her physician had recently taken her off Coumadin, because of complications from the drug. When the family returned the resident to the facility at approximately 4:15 on June 16, 2006, they reported to nursing staff, including Licensee, that the resident had exhibited several minutes of difficulty feeding herself, dropping utensils and speech difficulty. They also informed Licensee that the resident had complained of her right hand and arm going to sleep. The family requested that the doctor be notified. Licensee stated that she would notify the physician. Licensee failed to immediately page the doctor, did not document anything in the resident's chart and did not take any vital signs from the resident. Licensee faxed the information to the physician, but failed to attempt to call, or page the physician. The physician was out of the office on Friday, June 16 through Sunday, June 18, 2006. On Monday morning, June 19, the resident was found unresponsive by an aide at 0705. The resident suffered a stroke and was transferred to a hospital and died on June 23, 2006. A review of the patient's chart revealed that there were no nurse's notes from June 16 through June 18, 2006.	5/28/2008 to 5/28/2010
Todd W Roth Cape Girardeau MO	**RN2000163234**	On March 10, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 10 milligrams of Morphine to be administered to one of his patients ("JH"). Licensee administered to JH approximately six of the 10 milligrams of Morphine he withdrew for JH. Licensee did not document in JH's chart that he had done so. On March 10, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 10 milligrams of Morphine to be administered to another one of	5/31/2008 to 5/31/2009

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Name	License Number	Violation	Effective Dates of Probation
		his patients ("DG"). Licensee administered to DG approximately six of the 10 milligrams of Morphine he withdrew for DG. Licensee did not document in DG's chart that he had done so. Licensee wasted the remaining 4 milligrams of the 10 milligrams he withdrew for DG without a witness present. On March 10, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 10 milligrams of Morphine to be administered to another one of his patients ("TS"). Licensee administered to TS approximately six of the 10 milligrams of Morphine he withdrew for TS. Licensee did not document in TS's chart that he had done so. Licensee wasted the remaining 4 milligrams of the 10 milligrams he withdrew for TS without a witness present. On March 10, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 50 milligrams of Demerol to be administered to another one of his patients ("NO"). Licensee administered to NO approximately 25 of the 50 milligrams of Demerol he withdrew for NO. Licensee did not document in NO's chart that he had done so. On March 17, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 10 milligrams of Morphine to be administered to another one of his patients ("CP"). Licensee administered to CP the 10 milligrams of Morphine he withdrew for CP. Licensee did not document in CP's chart that he had done so. On March 17, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 10 milligrams of Morphine to be administered to another one of his patients ("KS"). Licensee administered to KS the 10 milligrams of Morphine he withdrew for KS. Licensee did not document in KS's chart that he had done so. On March 17, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 10 milligrams of Morphine to be administered to another one of his patients ("JP"). Licensee administered to JP approximately six of the 10 milligrams of Morphine he withdrew for JP. Licensee did not document in JP's chart that he had done so. On March 17, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 10 milligrams of Morphine to be administered to another one of his patients ("BS"). Licensee administered to BS approximately six of the 10 milligrams of Morphine he withdrew for BS. Licensee did not document in BS's chart that he had done so. On March 17, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 10 milligrams of Morphine to be administered to another one of his patients ("RB"). Licensee administered to RB approximately six of the 10 milligrams of Morphine he withdrew for RB. Licensee did not document in RB's chart that he had done so. On March 17, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 10 milligrams of Morphine to be administered to another one of his patients ("DP"). Licensee administered to DP approximately six of the 10 milligrams of Morphine he withdrew for DP. Licensee did not document in DP's chart that he had done so. On March 17, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 50 milligrams of Demerol to be administered to another one of his patients ("GE"). Licensee administered to GE the 50 milligrams of Demerol he withdrew for GE. Licensee did not document in GE's chart that he had done so. On March 17, 2005, Licensee withdrew from a medication dispensation area or machine at the facility approximately 50 milligrams of Demerol to be administered to another one of his patients ("PM"). Licensee administered to PM 25 of the 50 milligrams of Demerol he withdrew for PM. Licensee did not document in PM's chart that he had done so.	
Linda P Roughton St. Charles MO	**RN090067**	Licensee allowed nurses' aides to administer medication to residents. Licensee was terminated on October 31, 2006 for improper medication administration.	4/17/2008 to 4/17/2010
Paula Danette Schnelle Milan MO	**PN1999138406**	On June 19, 2005, Licensee was arrested for driving under the influence of alcohol. Licensee pled guilty to Driving with Excessive Blood Alcohol Content on April 15, 2005. Licensee received five days in jail. Licensee completed a 28 day rehabilitation program.	4/19/2008 to 4/19/2010
Rhonda Stephanie Buttelwerth-Sexton Cape Girardeau MO	**PN2005035452**	On July 7, 2006, Licensee received her first disciplinary action for sharp and discourteous behavior toward her co-workers. The nurse manager stated that on July 7, 2006 Licensee was "slamming things around, wouldn't talk to people, would demand things and was screaming at other employees." The nurse manager stated that her co-workers were intimidated by Licensee and Licensee's behavior was reported only when a nurse from another floor reported it. In December of 2006 peer evaluation were done on Licensee and due to the results, which were mostly negative, the nurse manager prepared a Work Performance Plan for Licensee. The nurse manager stated that the Work Performance Plan detailed an action plan to address Licensee's disrespectful behavior, time management, communication and a lack of confidence in her (Licensee's) skills. The plan was implemented on December 19, 2006. On	5/28/2008 to 5/28/2009

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Disciplinary Actions cont. from page 22

Name	License Number	Violation	Effective Dates of Probation
		February 2, 2007, another nurse manager received a telephone call at her home from her shift supervisor, working with Licensee. The shift manager reported that Licensee had been extremely rude to a patient and his wife during her shift on February 2, 2007 and stated that the incident was reported by an individual. The individual stated that Licensee was having trouble keeping the patient in his bed and at one point Licensee shouted at the individual "I can only do one thing at a time." An L.P.N., working at the time stated that she heard Licensee ask the patient's wife "What do you want me to do about it?" in a very inappropriate tone. The patient's wife told the individual that no one in the hospital had ever been so rude to her. Due to the February 2, 2007 incident, Licensee was terminated from her employment.	
Misti Faune Spor Lenexa KS	**RN2005010025**	On March 23, 2006, Licensee was convicted of Driving While Intoxicated and received a suspended imposition of sentence.	5/28/2008 to 5/28/2010
Letha Ann Talton Columbia MO	**PN2001009981**	On July 9, 2007, Licensee entered a plea of guilty to the Class C Felony of Stealing by Deceit. The Court sentenced Licensee to four years in the Department of Corrections, suspended execution of that sentence and placed Licensee on five (5) years of supervised probation. Licensee was ordered to pay restitution in the amount of $4,260.	4/15/2008 to 4/15/2009
Theresa K Thoman Kansas City KS	**PN049395**	While employed and assigned to work private duty in a home where there were foster children, a controlled drug came up missing and Licensee was named by the foster parents as someone who had access to the drug. On March 24, 2006, Licensee submitted to a drug screen, the results of which were positive for Cocaine.	3/19/2008 to 3/19/2013
Marjorie A Thomas Poplar Bluff MO	**RN113304**	As the supervising nurse for patients, Licensee was responsible for ensuring that physicians approved and signed all medication orders for patients. During the months of May through September 2004, Licensee administered medications to a patient, without a signed order from their physician. Licensee also failed to ensure that the patient's physician received and signed the medication orders. Licensee's failure to ensure that the patients' physician signed the medication order violated the facility's policy.	4/8/2008 to 4/8/2009
Christine Elizabeth Turner Saint Louis MO	**PN2007024825**	Licensee was required to abstain completely from the use or consumption of alcohol. On September 26, 2007, Licensee submitted a urine sample for random drug and alcohol screening. The sample tested positive for the presence of ethyl glucuronide, a metabolite of alcohol.	3/20/2008 to 7/29/2010
Chaney L Wisdom O Fallon MO	**RN151430**	On March 25, 2005, Licensee was assigned to care for a patient who had previously been admitted through the OB triage area. The patient was 34 weeks gestation and the physician plan was to attempt a vaginal birth after a prior C section. The standard on the OB unit for the hospital is to complete a RN assessment of a risk patient within 15 minutes of admission, which was completed in OB triage area and patient was transferred to a labor and delivery room at approximately 7:04 a.m. Licensee came on duty at 6:45 a.m. and was given report by the triage nurse. At 7:07 on March 25, Licensee went into the patient's room introduced herself and did an assessment of the patient which consisted of assessing the patient's tracing for fetal status, contraction levels and pain level; however, Licensee did not do a vaginal assessment of the mother. Licensee was present as the OB technician placed the patient on a fetal monitor in the patient's room. After leaving the patient's room Licensee met with two other staff members regarding scheduling, the meeting took place for approximately half an hour between 7:15 a.m. and 7:45 a.m. in the break room (staff room). During the time that Licensee was meeting with the staff members in the break room, the patient's fetal monitor alarm sounded five times at 7:22 a.m., 7:23 a.m., 7:29 a.m., 7:30 a.m. and 7:38 a.m. Each time the fetal monitor sounded, it was turned off by an unknown nurse at the nurse's station. Licensee stated that when she was in the break room she was suddenly alerted to her patient's condition at which point Licensee rushed into the patient's room.	4/19/2008 to 4/30/2008
Jan M Willman Saint Louis MO	**RN124055**	Licensee has a history of drug dependency. A report was received from Licensee's co-workers questioning narcotics withdrawn under their patients' name by Licensee. Licensee withdrew Demerol/Vistaril on a patient which was not assigned to her. The patient stated she never received the medication. Licensee admitted to misappropriating drugs from the unit and having a history of addiction to prescription Oxycontin and Oxycodone. Licensee refused a drug screen upon request because she did not want a positive screen in her record, so she wrote and signed a Statement of Admission. Licensee emptied her pockets upon request in the office which revealed an unopened bottle of Fentanyl which she said she was going to give to a patient at midnight and also a bottle of Hydroxyzine which was a component of the patient's pain med who reported never receiving her pain medication. Licensee diverted the medication by withdrawing more than the physician's order required.	4/17/2008 to 4/17/2013

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Name	License Number	Violation	Effective Dates of Probation
Donald R Wohlford Kansas City MO	**RN095687**	Licensee was responsible for obtaining orders, placing catheters, starting IV's and doing initial assessments. The patient was brought to the assessment area and assigned to Licensee. The patient was a 32 year old brittle diabetic, with Cellulitis, who was transferred for admission as an inpatient. The admission order on the patient stated to admit the patient to acute inpatient care and to call upon arriving. Several medication orders were written, including an order for Sliding Scale Insulin. The last order on the sheet stated to contact the attending physician, which was indicated as the physician at the top of the form, for review and continuation of the patient's routine medication. On February 12, 2007, Licensee transcribed orders noting that he had read back the verbal orders to the attending physician. Licensee failed to contact the physician who was going to be treating the patient about the orders. When questioned, Licensee admitted that the physician did not give him orders and that he had falsified the records. Licensee failed to properly contact the appropriate physician, which resulted in a delay of several hours before a physician saw the patient. The patient died on February 13, 2007, due to pulmonary emboli.	5/8/2008 to 5/8/2010
Edith M Young Saint Louis MO	**PN037991**	Between May 27, 2004 and July 6, 2004, the resident was one of Licensee's patients at the skilled nursing facility. Between May 27, 2004 and July 4, 2004, the resident's temperature ranged from about 96 degrees Fahrenheit to 100.7 degrees Fahrenheit. Between May 27, 2004 and July 4, 2004, the resident's phlegm remained white and frothy. On July 5 and 6, 2004, the resident had a primary care provider. On July 5, 2004, the staff documented in the resident's chart that at 9:00 a.m. that day, the resident had had a temperature of 104.6 degrees Fahrenheit and thick, yellowish phlegm. The resident's 104.6 degree temperature and thick, yellowish phlegm collectively constituted a change in patient condition. On July 5, 2004, the staff documented in the resident's chart that at 2:30 p.m. that day, the resident had had a temperature of 103.7 degrees Fahrenheit. The resident's 103.7 degree temperature at 2:30 p.m. on July 5, 2004 constituted a continuing change in patient condition. On July 5, 2004, the staff documented in the resident's chart that in response to resident's 104.6 degree temperature and thick, yellowish phlegm at 9:00 a.m. that day, the nurse on the shift prior to Licensee's shift performed suctioning on the resident and administered Tylenol and ice packs. On July 5, 2004, the staff also documented in the resident's chart that at 2:30 p.m. that day, the resident's temperature was 103.7 degrees Fahrenheit. The resident's 103.7 degree temperature at 2:30 p.m. on July 5, 2004 constituted a patient being non-responsive to previously	4/2/2008 to 4/2/2009

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Name	License Number	Violation	Effective Dates of Probation
		administered treatment. Licensee did not notify the primary care provider or any physician that the resident had had a 104.6 degree temperature and thick, yellowish phlegm at 9:00 a.m. on July 5, 2004, nor did the Licensee notify the primary care provider or any physician that the resident had had a 103.7 degree temperature at 2:30 p.m. that same day. On July 5, 2004, Licensee made an entry on the resident's chart, which documented that the resident had a temperature of 100 degrees Fahrenheit and that the resident had been producing "much phlegm"; however, Licensee did not document when the resident's temperature was taken, nor did Licensee describe the color or consistency of the resident's phlegm. Licensee's documentation on July 5, 2004 was not clear, descriptive, or thorough. On July 6, 2004, the staff documented in the resident's chart that at 6:00 a.m. that day, the resident had a fixed stare. On July 6, 2004, the staff also documented in the resident's charts that at 9:00 a.m. that day, the resident had had a temperature of 103.2 degrees Fahrenheit, rapid respirations, and brown tinged phlegm. The resident's 103.2 degree temperature, rapid respirations, and brown tinged phlegm at approximately 9:00 a.m. on or about July 6, 2004 collectively constituted a change in patient condition. On July 6, 2004, the staff also documented in the resident's charts that at 2:30 p.m. that day, the resident had had a temperature of 103.1 degrees Fahrenheit. The resident's 103.1 degree temperature at 2:30 p.m. on July 6, 2004 constituted a continuing change in patient condition. On July 6, 2004, the staff documented in the resident's chart that in response to the resident's fixed stare that occurred at 6:00 a.m. that day and 103.2 degree temperature, rapid respirations, and brown tinged phlegm that	

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Name	License Number	Violation	Effective Dates of Suspension/Probation
		occurred at 9:00 a.m. that day, the nurse on the shift prior to Licensee's shift performed suctioning on the resident and administered Tylenol. On July 6, 2004, the staff documented in the resident's chart that at 2:30 p.m. that day, the resident had had a temperature of 103.1 degrees Fahrenheit. The resident's 103.1 degree temperature at 2:30 p.m. on July 6, 2004 constituted a patient being non-responsive to previously administered treatment. The Licensee did not notify the primary care provider or any physician that the resident had had a 103.2 degree temperature, rapid respirations, brown tinged phlegm, and a fixed stare between 6:00 a.m. and 9:00 a.m. on July 6, 2004, nor did Licensee notify the primary care provider or any physician that the resident had had a 103.1 degree temperature at 2:30 p.m. that same day. On July 6, 2004, Licensee made an entry in the resident's chart, which included the abbreviation "TF". The abbreviation "TF" was not an abbreviation approved by the skilled nursing facility, nor can its meaning be ascertained. On July 6, 2004, one of Licensee's entries indicated that the resident had a temperature of 100 degrees Fahrenheit; however, the same entry indicated that the resident had a temperature of 99 degrees Fahrenheit. On July 6, 2004, one of Licensee's entries indicated that Licensee treated the resident at 5:00 p.m.; however, the same entry also indicated that Licensee treated the resident at 7:00 p.m. Licensee's documentation on July 6, 2004 was not clear, descriptive, or thorough. On July 6, 2004, at approximately 11:00 p.m., the resident died.	

SUSPENSION/PROBATION

Name	License Number	Violation	Effective Dates of Suspension/Probation
Colette R Carey Hallsville MO	**RN139818**	On September 26, 2005, Licensee pled guilty to a felony charge of Possession of a Controlled Substance. The Circuit Court entered its judgement in the case on November 7, 2005, accepting Licensee's plea and finding Licensee guilty.	Suspension 3/19/2008 to 3/19/2009 Probation 3/19/2009 to 3/19/2014

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REVOKED

Name	License Number	Violation	Effective Dates of Revocation
Nicole Louise Berry Imperial MO	**RN2007031165**	Licensee violated the terms of her probation by failing to complete the contract process with NCPS, Inc; and by failing to submit employer evaluations by the due date.	3/13/2008
Stephney A Brown Kansas City MO	**PN056554**	Licensee violated the terms of her probation by failing to adhere to the terms of her NCPS agreement; failure to submit Employer Evaluations by the due dates and failure to submit evidence of weekly (or recommended) attendance at AA, NA or support group meetings.	3/13/2008
Judith A Goodman Malta Bend MO	**PN048352**	Licensee admitted to inappropriate physical conduct with a consumer. Licensee admits to sexual contact and sexual intercourse with the consumer in locations within the facility.	3/13/2008
Ann M Laas Gravois Mills MO	**PN041034**	Licensee violated the terms of her probation by failing to complete the contract process with NCPS, Inc and for failing to submit a chemical dependency evaluation.	3/13/2008
Colby S McClain Saint Joseph MO	**RN146373**	Licensee removed narcotics without proper documentation/ witnessing on several occasions. Licensee admitted to consuming some, not all of the diverted narcotics.	3/13/2008
Karen L Moody Portageville MO	**RN2002022031**	Licensee violated the terms of her probation by failing to submit a letter from the Arkansas State Board of Nursing outlining licensee's progress and probation status with the state of Arkansas.	3/13/2008
Carla D Nay Pleasant Valley MO	**PN055811**	Licensee tested positive for Amphetamines, Methamphetamines, Oxazepam and Cocaine.	3/13/2008
Angela K Plemmons Republic MO	**PN050952**	Licensee was dismissed from employment for not being able to produce her nursing license and for dependability. After being terminated, licensee was seen visiting a patient at the facility and was suspected of taking a fentanyl patch. On a later visit, licensee was observed by staff on a video, attempting to remove a fentanyl patch from a resident.	3/13/2008
Joyce B Prusaczyk Saint Louis MO	**RN050128**	Licensee violated the terms of her probation by failing to contract with NCPS, Inc; failing to meet with a representative of the Board and for her failure to submit a Chemical Dependency Evaluation.	3/13/2008
Tina L Rotermund Lewis Center OH	**RN132929**	Licensee violated the terms of her probation by failing to complete the registration process with NCPS, Inc; and for failure to submit a chemical dependency evaluation.	3/13/2008
Joni Michelle Stanley Jefferson City MO	**PN2006026512**	Licensee violated the terms of her probation by testing positive for alcohol on October 11, 2007 and December 26, 2007.	3/13/2008

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VOLUNTARY SURRENDER

Name	License Number	Violation	Effective Dates of Voluntary Surrender
Stephanie Lynn Brinkman Washburn MO	**PN2004025453**	Licensee tested positive for marijuana on June 1, 2007 during a random drug screen. Licensee admitted to smoking "a joint" six days before the drug screen.	3/15/2008
Rose M Bush Parnell MO	**RN147115**	Licensee failed to notify the physician of changes in a patient's condition. Approximately ten days later the resident died.	4/17/2008
Brenda S Estes Alton IL	**RN150624**	Licensee was convicted on May 27, 2005, in Madison County Illinois, on a class four felony of Unlawful Acquisition of a Controlled Substance and a class three felony of forgery in the state of Illinois. In 2003, Licensee diverted Demerol from a clinical site. When she tried to return the drugs to the pharmacy, an analysis was done and it was found the specimens returned by Licensee labeled Demerol contained saline. In January, 2003, Licensee was terminated from employment for diverting Meperdine and Demerol. In October of 2004, licensee was terminated from St. John's Mercy Hospital for falsifying information on her employment application.	3/29/2008
Alice Faye Haney Sarcoxie MO	**PN2006038437**	On December 15, 2007 and again on December 16, 2007, Licensee took Benadryl from one resident's medications and administered it to a different resident who did not have an order for Benadryl	5/31/2008
Cynthia A Jackson Saint Louis MO	**RN091437**		5/29/2008
Paula Susan Larery Pittsburg KS	**RN2001022329**	In August of 2005, Licensee had removed 140 more doses of Demerol than any other nurse that month. The comparison of the Pyxis report and patients' charts revealed that Licensee was administering large amounts of Demerol to patients, within short periods of time. Hospital personnel interviewed three patients who were charted as receiving several large doses of Demerol. Patient 1 stated she received no pain medication during the shift where Licensee documented administering 15 doses, 275 mg. of Demerol. Patient 2 stated that she received no pain medication during the shift where Licensee documented administering 14 doses-575 mg. Patient 3 stated she received two (2) doses of pain medication during the shift where Licensee documented administering 14 doses, 300 mg. Licensee was asked to submit to a "for cause" urine drug screen and refused to be tested and resigned her position from the hospital. Licensee admitted to a Board of Nursing Investigator that licensee had been diverting Demerol from the hospital from July 2005 through September 2005.	5/15/2008
Katy A Scott Louisiana MO	**RN045180**	Licensee failed to properly or timely document the assessment or interventions of her care of her patients. Licensee failed to follow through on doctor's orders in a timely manner.	5/1/2008

Did you know you are required to notify the Board if you change your name or address?

Missouri Code of State Regulation [(20 CSR 2200-4.020 (14)(b) (1)] says in part "If a change of name has occurred since the issuance of the current license, the licensee must notify the board of the name change in writing . . ." and (2) If a change of address has occurred since the issuance of the current license, the licensee must notify the board of the address change . . ."

Note: change of address forms submitted to the post office will not ensure a change of address with the Board office. Please notify the board office directly of any changes.

Type or print your change information on the form below and submit to the Board Office by fax or mail. ***Name and/or address changes require a written, signed submission. Please submit your change(s) by:***

• Fax: 573-751-6745 or 573-751-0075 or

• Mail: Missouri State Board of Nursing, P O Box 656, Jefferson City, MO 65102

Please complete all fields to ensure proper identification.		
❒ RN ❒ LPN		
Missouri License Number		
Date of Birth		
Social Security Number		
Daytime Phone Number		
OLD INFORMATION (please print):		
First Name	Last Name	
Address		
City	State	Zip Code
NEW INFORMATION (please print)		
First Name	Last Name	
Address (if your address is a PO Box , you must also provide a street address):		
City	State	Zip Code
Signature (required)		
Date		

Duplicate license instructions:

It is not mandatory that you obtain a duplicate license. You may practice nursing in Missouri as long as your Missouri nursing license is current and valid. If you wish to request a duplicate license reflecting your new name, you must return ALL current evidence of licensure and the required fee of $15.00 for processing a duplicate license.

Return this completed form to: Missouri State Board of Nursing, P O Box 656, Jefferson City, MO 65102

Is Your License Lost or Has It Been Stolen?

If you would like to obtain a duplicate license because your license has been lost or stolen. Please contact our office and request an Affidavit for Duplicate License form or you may obtain it from the Licensure Information & Forms tab on our website at http://pr.mo.gov/nursing.asp